Supreme Court, U.S.
FILED

00 966 DEC -7 2000

OFFICE OF THE CLERK

No.

IN THE

SUPREME COURT OF THE UNITED STATES

SAJID L. SYED,

Petitioner,

vs.

HERCULES INCORPORATED, a Delaware Corporation; HERCULES INCORPORATED INCOME PROTECTION PLAN, an employee welfare benefit plan ; and HERCULES INCORPORATED, Plan Administrator of DISABILITY PLAN,

Respondents.

Petition for a writ of Certiorari to the United States Court of Appeals for the Third Circuit

PETITION FOR A WRIT OF CERTIORARI

SAJID L. SYED
Pro se
3805 Eunice Ave.
Wilmington, DE 19808
(302) 999-9066

QUESTIONS PRESENTED

1. Whether the Third Circuit erred in allowing a plan administrator to assert a one-year statute of limitations period contrary to the unambiguous provision of the plan which stated a three-year statute of limitations period was applicable.

2. Whether the Third Circuit's decision of not applying Delaware's three-year statute of limitations as most analogous for a claim under ERISA § 502 (a)(1)(B) disrupts the uniformity of law intended by Congress.

3. Whether an ERISA plan administrator after committing "Fraud On Federal Courts" and after violating 29 U.S.C. Sections 1021(a), 1024(b), and 1104(a), still procure a favorable decision on summary judgment related to the issues violated.

4. Is Summary Judgment proper when Material Facts are in dispute ?

5. Whether an insurance policy which meets all the statutory requirements of 29 U.S.C. § 1022(b) may be ignored in favor of an SPD which violates 29 U.S.C. § 1022(b) and backdated more than five years.

6. Whether Syed has been denied Due Process of Law.

PARTIES TO THE PROCEEDING

All parties to the proceeding are listed in the caption of the case.

TABLE OF CONTENTS

	Page
QUESTIONS PRESENTED	i
PARTIES TO THE PROCEEDINGS	ii
TABLE OF AUTHORITIES	v
OPINIONS BELOW	1
JURISDICTION	1
STATUTES AND REGULATIONS INVOLVED	1
STATEMENT OF THE CASE	2
REASONS FOR GRANTING THE WRIT	5
I. THE THIRD CIRCUIT'S DECISION CONTROVERTS THE PLAIN LANGUAGE OF THE PLAN DOCUMENT.	5
II. THE THIRD CIRCUIT'S DECISION OF NOT SELECTING 10 DEL.C. § 8106 AS MOST ANALOGOUS FOR A CLAIM UNDER ERISA § 502 (a)(1)(B) DISRUPTS THE UNIFORMITY OF LAW INTENDED BY CONGRESS.	10
III. THIRD CIRCUIT FAILED TO REALIZE THAT RESPONDENTS VIOLATED 29 U.S.C. § 1021(a), § 1024(b), § 1104(a), AND COMMITTED "FRAUD ON FEDERAL COURTS"	17
IV. SUMMARY JUDGMENT WAS NOT PROPER ON SYED'S § 502 (c) CALIM WHEN MATERIAL FACT WAS IN DISPUTE.	22

TABLE OF CONTENTS

Page

V. THE THIRD CIRCUIT ERRED IN IGNORING THE INSURANCE POLICY WHICH MEETS ALL THE STATUTORY REQUIREMENTS OF ERISA AND 29 U.S.C. § 1022 (b). 25

VI. THE THIRD CIRCUIT DENIED SYED DUE PROCESS OF LAW IN IGNORING HIS PLEADINGS. 28

CONCLUSION 30

TABLE OF AUTHORITIES

CASES

	Page
Adamson v. Armco, 44 F.3d 650, 652 (8th Cir. 1995)	11
Armstrong v. Manzo, 380 U.S. 545, 552, 85 S. Ct. 1187, 1191 (1965)	29
Atlantic Mut. Ins. Co. v. Brotech Corp., 857 F.Supp. 423, 427 (E.D. Pa. 1994)	9
Bay Area Laundry Pension Fund v. Ferbar Corp., 522 U.S. 192, 118 S.Ct. 542, 139 L.Ed.2d 553 (1997	15
Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986)	22
Curtis-Wright Corp. v. Schoonejongen, 514 U.S. 78, 84 (1995)	16
Dade v. North American Philips Corp., 68 F.3d 1558, 1561 (3d Cir. 1995)	7
Daill v. Sheet Metal Workers' Local 73 Pension Fund, 100 F.3d 62, 65 (7th Cir. 1996)	
Dameron v. Sinai Hosp., 815 F.2d 975, 981 (4th Cir. 1987	11
DelCostello v. International Bhd. of Teamsters, 462 U.S. 151, 158-60 (1983)	11
Dist. No. 15 Machinists' Fund v. Kahle Engr. Corp., 43 F.3d 852, 857-861 (3rd Cir. 1994)	15,16
Duchek v. Blue Cross and Blue Shield of Nebraska, 153 F.3d 648, 649-50 (8th Cir. 1998)	9

Epright v. Environmental Resources Management,
81 F.3d 335, 342, 343 (3rd Cir. 1996) 6,18

Godwin v. Sunlife Assur. Co. of Canada,
980 F.2d 323,324 (5th Cir. 1992); 27

Harrison v. Digital Health Plan, 183 F.3d 1235,
1239-40 (11th Cir. 1999); 11,14

Harte v. Bethlehem Steel Corp. 5,6

*Hawii Carpenters Trust Funds v. Waiola Carpenter
Shop, Inc.*, 823 F.2d 289, 298 (9th Cir. 1987). 16

Hazel-Atlas Glass Co. v. Hartford Empire Co., 322 U.S.
238, 245-46, 64 S.Ct. 997, 1000-01, 88 L.Ed. 1250 (1944) 22

Held v. Manufacturers Hanover Leasing Corp.,
912 F.2d 1197, 1207 (10th Cir. 1990) 11

Hofkin v. Provident Life & Acc. Ins. Co.,
81 F.3d 365, 367, 371, 372 (3rd Cir. 1996). 9

Hogan v. Kraft Foods, 969 F.2d 142, 145 (5th Cir. 1992) 11

Hughes v. Boston Mutual Life Ins. Co., 26 F.3d 264,
266 (1st Cir. 1994) 27

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990). 10

Jackson v. American Can Co., 485 F.Supp. 370
(W.D. Mich. 1980) 16

Johnson v. State Mutual Life Assur. Co. of America,
942 F.2d 1260,1262 (8th Cir. 1991); 28

Kunstenaar v. Conn. Gen. Life Ins. Co.
902 F.2d 181 (2d Cir. 1990) 27

Lang v. *Aetna Life Ins. Co.*, 196 F.3d 1102, 1104
(10th Cir. 1999) 10

Loving v. Pirelli Cable Corp., (3rd Cir. No. 95-7597 dated
August 21, 1996). 11,12

Loving v. Pirelli Cable Corp. et.al., 11 F. Supp.2d
480, 483, 484 (D.Del. 1998) 11,12

Massachusetts Mut. Life ins. co. v. Russell,
473 U.S. 134 (1985) 22

Mathews v. Eldridge, 424 U.S. 319,
333, 96 S. Ct. 893, 902 (1976) 29

Medoy v. Warnaco Disability Plan, 43 F.Supp.2d 303,
305 (E.D.N.Y. 1999 27

Meade v. Pension Appeals & Review Comm.,
966 F.2d 190, 195 (6th Cir. 1992) 11

Mitchell v. E.I. DuPont de Nemours & Co.,
310 A.2d 641, 642 (Del. 1973), 12,13

Mongeluzo v. Baxter Travenol Disability Ben. Plan,
46 F.3d 938, 940 (9th Cir. 1995) 28

Morse v. Stanley, 732 F.2d 1139 , 1147 (2d Cir. 1984) 7

Nikaido v. Centennial Life Ins. Co., 42 F.3d 557, 559
(9th Cir. 1994) 9

Occidental Life Insurance Co. v. EEOC, 432 U.S. 355,367 (1977). 12

Pierce County Hotel Employees & Restaurant Employees Health Trust v. Elks Lodge, 827 F.2d 1324, 1328 (9th Cir. 1987) 11

Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 52-57 (1987). 16

Pohl v. National Benefits Consultants, Inc., 956 F.2d 126, 128 (7th Cir. 1992) 16

Ramsey v. Hercules Inc., et.al., Cause No: TH93-215-C, and 77 F.3d 199 (7th Cir. 1996). 18,19,24

Read v. Local Lodge 1284, 528 F.2d 823 (3rd Cir. 1975). 13

Reinking v. Philadelphia Am. Life Ins. Co. 910 F.2d 1210, 1213-1214 (4th. Cir. 1990) 27

Riley v. UNUM, 28 F. Supp.2d 639, 640 (D.Kan.1998). 28

Rowan v. UNUM, 119 F.3d 433,434 (6th. Cir 1997) 27

Shaw v. Aetna Life Ins. Co., 395 A.2d 384 (Del. Super, 1978) 13

Siegal Transfer, Inc. v. Carrier Express, Inc., 54 F.3d 1125, 1127 (3d Cir. 1995). 23

Snyder v. Titus, 513 F. Supp. 926, 934 (E.D. Va.1981) 18

Smith v. Contini, 205 F.3d 597, 605 (3rd Cir. 2000 6,7

The Stop & Shop Companies, Inc. v. Gonzales, 619 A.2d 896 (Del. Supreme 1993). 7

Todish v. Cigna Corp., 206 F.3d 303 (3rd Circuit 2000) 17

Varity Corp. v. Howe, 116 S. Ct. 1065 (1996). 7

Vassallo v. Haber Elec. Co. 435 A.2d 1046, 1051 (Del. Super 1981) 13

STATUTES AND REGULATIONS

29 U.S.C. § 1021(a) 17,21
29 U.S.C. § 1022(b) 18,25,26
29 U.S.C. § 1024 (b) 21
29 U.S.C. § 1104 17,21
29 U.S.C. § 1113. 17
29 U.S.C. § 1132 (a)(1)(B), 9,10,14,16
ERISA § 502 (a)(1)(B 17,25

29 U.S.C. § 1132 (c)(1) , ERISA § 502 (c)(1) 21, 22,23,25
29 U.S.C. § 1133 , ERISA § 503 17,22

42 U.S.C. § 1983 29

29 C.F.R. § 2520.102-3(q)

10 Del. C. § 8106. 9,11,13

10 Del. C. § 8111. 10,13,14,16

18 Del. C § 3914 7
19 Del. C. 2361 14,15
19 Del. C. 3315 9

Petitioner, Sajid L. Syed ("Syed"), respectfully submits that a writ of certiorari should issue to review the judgment and opinion of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals and the dissent thereto were entered on May 30, 2000, and are reported at 214 F.3d 155 (3d Cir. 2000) and are reprinted in the Appendix ("APP.") at 1a-26a. The Court of Appeals' denial of Syed's petition for rehearing, with a suggestion for rehearing en banc, entered on July 10, 2000, is unreported. App. at 27a-28a. The District Court's opinion granting summary judgment to Respondents (App. at 29a-46a) is unreported. The District Court's order denying Syed's "Motion For Reconsideration" (App. at 47a-50a) is unreported. The District Court's order granting Syed's " Application to Add Party" (App. at 56a-57a) is unreported.

JURISDICTION

The Court of Appeals' order denying Syed's petition for rehearing, with a suggestion for rehearing en banc, was entered on July 10, 2000. On October 3, 2000, Justice Souter extended the time for filing this petition to and including December 7, 2000. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves the statutes and regulations set forth at App. 68a-78a.

STATEMENT OF THE CASE

This is an ERISA action in which Petitioner Sajid L. Syed ("Syed") seeks continued disability benefit entitlement under Hercules Incorporated Income Protection Plan ("Plan") based on his disability at the time of termination of his employment. Syed's disability resulted from a work accident on January 31, 1992. Syed's employment was terminated as of March 31, 1992. Federal Social Security Administration has determined that Syed has been totally disabled from any work as of January 31, 1992. The employer ("Respondents") has agreed that Syed has been permanently partially disabled under the State of Delaware Workers' Compensation Act. Syed was paid total disability benefits available under the plan for two years from April 1, 1992 until March 31, 1994.

When Syed started his employment with Hercules Incorporated ("Respondents") in September 1988, he was provided with a benefit booklet entitled " Your Hercules Benefits Portfolio, Income Protection, Short Term Disability - Long Term Disability" ("portfolio") as the plan document for short term and long term disability. On March 27, 1992, Syed met with his personnel manager who provided Syed with the same portfolio and advised him it was the plan document for disability benefits. On May 2, 1994, Syed requested in writing "I am requesting that Hercules Inc. provide me with an original brochure explaining Long Term Disability benefits in detail." A copy of portfolio was provided to Syed on July 20, 1994 by Mr. Patrick C. Donahue. This portfolio did not mention Provident Life and Accident Insurance Company as the claims fiduciary in it pursuant to the statutory requirements of 29 U.S.C. § 1022(b). On February 24, 1995, Syed requested in writing ", . . . kindly forward to me a complete copy of LTD Plan document effective as of March 4, 1992." Again, a copy of

portfolio was provided to Syed as the governing plan document by Patrick C. Donahue on March 22, 1995. App. at 65a.

On April 4, 1994, Syed was advised that his benefits were terminated as of March 31, 1994. Syed filed this action in the District of Delaware on February 6, 1996 as a claim for benefits under the Plan, and for sanctions due to lack of disclosure of a written request for the Plan document in effect as of the date of his termination . Syed's claim filed in February, 1996 was due to his benefits termination as of March 31, 1994, a period less than two years from the cessation of benefits payments.

Although, the portfolio advised Syed that a three-year statute of limitations was available to file a legal action, Respondents asserted the claim was untimely due to a Delaware one-year statue of limitations for wage claims. The District Court determined that this one-year statute of limitations for wage claims applied to Syed's disability claims under the Plan. Syed countered the assertion of a one-year limitations period by stating that his benefits claims should have had utilized the Delaware three-year statue of limitations period for actions on a contract or statute. The District Court concluded that one-year limitations period was applicable to Syed's claim.

Syed also asserted a claim under ERISA § 502 (c) because no current plan document was provided to Syed pursuant to a written request. Because the Summary Plan Description Provided to Syed by the Respondents did not even mention Provident Life and Accident Insurance Company ("Provident") in it, Syed knew it was not the proper plan document. In order to make sure if he was provided the latest copy of the plan document, Syed spoke with Mr. Patrick C. Donahue on March 24, 1995 who assured Syed that portfolio was still the plan document.

Syed's attorney made a mistake and attached a copy of wrong SPD with "Plaintiff's Brief In Support Of Plaintiff's Motion For Summary Judgment" filed on October 26, 1998. He later tried to correct it but was not allowed to do so by the District Court. (App. at 32a n.5). This mistake did not cause any prejudice to Respondents because Respondents did not include the portfolio in their opening brief in support of their motion for summary judgment. Respondent submitted a different SPD which was not disclosed to Syed in response to his written requests for a plan document. This SPD mentioned Provident as Claims Fiduciary in it.

On April 1, 1999, two months prior to the District Court's decision in this case dated May 27, 1999, Syeds' attorney filed an "Application for amendment of complaint to add party" (App. at 51a-55a). The sole basis for this application was that the portfolio (SPD) provided to Syed mentioned John Hancock Mutual Life Insurance Company, Policy Number 26701-GTC, as the insurance company and did not even mention Provident in it (App. at 54a). The District Court granted this application in an order dated July 14, 1999 (App. at 56a-57a), accepting Syeds' contention that the SPD submitted by Respondents to the the District Court and the Third Circuit as the governing plan document, was not provided to Syed.

After the District Court entered a summary judgment against Syed and in favor of Respondents on all issues, Syed appealed to the Third Circuit. In his "Opening Brief On Appeal Of Appellant", Syed submitted the portfolio as the plan document. Again, Respondents concealed the portfolio from the Third Circuit and did not contest Syed's submission to Third Circuit that portfolio was provided to Syed as the plan document. Since Respondents did not object to Syed's submission of portfolio to the Third Circuit, in their answering brief to Third Circuit, Syed advised

Third Circuit as follows in his "reply brief" under "statement of issues presented for review" as follow:

> Appellees address this issue and do not contest its presentation. Appellant therefore views the issue of whether a valid and proper plan document applicable to a benefits claim under an ERISA plan is properly before the Court.

"Appellant's Reply Brief On Appeal" at page 2. During the Oral Argument , Syed's attorney again made it very clear to the Third Circuit that portfolio was provided to Syed as the plan document. Syed learned after the Third Circuit decided the case on May 30, 2000 that all of Syed's contentions were ignored by the Third Circuit. Third Circuit failed to address the issue of the plan provision which advised Syed that a three-year statute of limitations was available to file a legal action.

REASONS FOR GRANTING THE WRIT

I. THE THIRD CIRCUIT'S DECISION CONTROVERTS THE PLAIN LANGUAGE OF THE PLAN DOCUMENT.

1. The Third Circuit has brought itself sharply into conflict with other Circuits on important federal issues which require uniformity nationwide. The Third Circuit erred in allowing an ERISA Plan Administrator and Fiduciary to assert a limitation period which controverts the plain language of the plan provisions. *Harte v. Bethlehem Steel Corp.* , 204 F.3d 442, 447, 449 (3rd Cir. 2000) is a recognition that a fiduciary breach occurs when disclosure

violations have resulted from failure to keep a claimant fully informed to the extent that he or she is not provided misleading information on which retirement decisions are to be based. The provisions of portfolio, SPD, or insurance policy , which items were repeatedly referred to in the May 30, 2000 Opinion all contain a three-year limitations period for filing a legal action. Syed took these communications as indicating that he had ample time to pursue his claims before the Respondents would object to his filing a court action. The Respondents have asserted a statute of limitations period that does not exist in any of the plan (s) and are thus committing the very fiduciary breach *Harte* sought to protect against. *Harte* was also cited by *Smith v. Contini* , 205 F.3d 597, 605 (3rd Cir. 2000), to affirm that a plan administrator fiduciary acting consistently with a plan nevertheless may breach its fiduciary duty. Delaware claimants need to know if the fiduciary breach thus spelled out is a violation of ERISA that also needs to be asserted within a one-year period. Because Syed could read any one of three offerings (portfolio, SPD, or insurance policy) to find that he had three years to file an action, he was deceived, and therefore "damaged" because his case has not been filed within "one year."

2. Syed brought this case under the terms of his ERISA plan and submits to this Court that it was a legal error on part of the Respondents and the Third Circuit to search for a different statute of limitations period extrinsic to the provisions of the plan. See *Epright v. Environmental Resources Management*, 81 F.3d 335, 342, 343 (3rd Cir. 1996) where the Third Circuit held an interpretation of the plan to be arbitrary and capricious if standards for coverage are imposed which are not required by the plan itself. "By imposing a requirement which is extrinsic to the Plan, ERM acted arbitrarily and capriciously . . . Accordingly, there was no reasonable basis for the Plan Administrator's denial of benefits." *Id.*, at 343. The plan did provide for a three-year period and Syed submits that the plan's provision must be

applied and a search for an applicable statute of limitations should only be conducted if the plan document was silent on the issue. See the following quote from the Third Circuit's Opinion in *Smith, Supra,* dated March 9, 2000 citing *Dade v. North American Philips Corp.*, 68 F.3d 1558, 1561 (3d Cir. 1995):

> "Thus, ordinarily only the plan can create an entitlement to benefits. Consequently, "we are required to enforce the Plan as written unless we can find a provision of ERISA that contains a contrary directive."

Dade, 68 F.3d at 1562. Syed urges this Court to direct the Third Circuit to simply follow its own previous decisions in *Smith* and *Dade* and follow the statutory directions of ERISA.

3. This Court has previously concluded "employer violated fiduciary obligations of ERISA in misleading employees". See *Varity Corp. v. Howe*, 116 S. Ct. 1065 (1996). Under 29 U.S.C. § 1102 (a)(1), App. at 72a, "[e]very employee benefit plan shall be established and maintained pursuant to a written instrument. . . ." The plan description "shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan." This summary plan description must not mislead, misinform, or fail to inform participants and beneficiaries of the Plan. *Morse v. Stanley, 732 F.2d 1139 , 1147* (2d Cir. 1984) (citing 29 C.F.R. § 2520.102(b) (1983)). In this case, the Respondent advised Syed (via plan documents) that a three-year statute of limitations was applicable and never advised him about the applicability of a one-year period until the claim was filed. Respondents violated statutory requirements of 18 Del. C. § 3914, App. at 78a. *See The Stop & Shop Companies, Inc. v. Gonzales* , 619 A.2d 896 (Del. Supreme 1993). Indeed, it will

be a manifest injustice if the Respondents were allowed to assert a one-year statute of limitations after violating federal and state statutes.

4. Syed refers this Court to the provision of portfolio provided to him as the plan document during 1988 and 1995 as follows:

> **Statute of Limitations**
>
> Proof of loss not submitted within 90 days from the time such proof is otherwise required, except in the case of absence of legal capacity, may invalidate a claim for benefits. No action at law shall be brought to recover on this policy after the expiration of 3 years after the time written proof of loss is required to be furnished.
>
> Claims for benefits must be filed within twelve months of when an employee ceases active work to be considered.

Portfolio at page 10.

The insurance policy (M-462-LTD) which went into effect as of July 1, 1990 and under which Syed was paid benefits, contains the following provision:

> **Legal Actions**
>
> No action will be brought to recover under the Plan until 60 days after proof of disability has been given. No action can be brought after 3 years from the date such written proof is required.

Policy No. M-462-LTD at page 17 and SPD at page 12.

Syed's benefits were terminated as of March 31, 1994 and he received the termination letter on April 4, 1994. Syed's

claim was filed on February 6, 1996 and was timely filed within 3 years as required by the policy. This 3 year requirement in the policy is consistent with Delaware's three-year statute of limitations for claims alleging breach of insurance policies, 19 De. C. § 3315. Other Circuits have concluded that similar state statutes are the most analogous to § 502 (a)(1)(B) claims and supply the appropriate statute of limitations. *See, e.g., Lang* v. *Aetna Life Ins. Co.*, 196 F.3d 1102, 1104 (10th Cir. 1999) ("Our duty . . . is to choose the most analogous state statute of limitation. While plaintiff 's ERISA claim is based upon a contract, it is more precisely based upon a contract of insurance. Therefore, we hold that the three-year statute of limitations applies to plaintiff 's claim."); *Nikaido v. Centennial Life Ins. Co.*, 42 F.3d 557, 559 (9th Cir. 1994)(using California's "limitations statute specifically for disability policies" rather than general breach of contract statute where ERISA Plan contained provision similar to that of California's insurance code); *Duchek v. Blue Cross and Blue Shield of Nebraska*, 153 F.3d 648, 649-50 (8th Cir. 1998) (applying Nebraska Insurance Statute to action for benefits under ERISA). As the *Duchek* Court put it:

> [I]t would be anomalous to characterize this suit as a contract action and then borrow Nebraska's generic contract statute of limitations rather than the specific section of the Nebraska insurance laws permitting the contractual limitation in question.

153 F.3d at 649-50. Indeed, the Third Circuit has previously acknowledged that the policy provisions must be enforced. *See Hofkin v. Provident Life & Acc. Ins. Co.*, 81 F.3d 365, 367, 371, 372 (3rd Cir. 1996). *See id*, at 371, ". . . A court, however, should not torture the language of the policy to create ambiguities." citing *Atlantic Mut. Ins. Co. v. Brotech*

Corp., 857 F.Supp. 423, 427 (E.D. Pa. 1994) (citations omitted), *aff'd* 60 F.3d 813 (3rd Cir. 1995).

II. THE THIRD CIRCUIT'S DECISION OF NOT SELECTING 10 DEL.C. § 8106 AS MOST ANALOGOUS FOR A CLAIM UNDER ERISA § 502 (a)(1)(B) DISRUPTS THE UNIFORMITY OF LAW INTENDED BY CONGRESS.

5. The Third Circuit's decision adopting 10 Del. C. § 8111 as most analogous for claims under ERISA § 502(a)(1)(B) should be reviewed not only because it creates significant conflicts among all other Circuits, but also because it has a far ranging impact which destroys ERISA's key objectives of providing employees with the promised benefits. As this Court has noted, the "potential for conflict in substantive law" is "[p]articulary disruptive" under ERISA. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990). The decision's severe repercussions—which will create a crazy quilt of conflicting plan rules across the land—warrant swift intervention by this Court. If this Court does not correct the obvious wrong decision by the Third Circuit, the plan administrators all over this land will be acting to deprive employees of their benefits if the claims were not filed within one year. The result is obvious—federal courts will be facing enormous amount of unnecessary litigation which would not only place the employees in a financial hardship, but will also cause them to not to trust the written plan instructions. The employers will be free to assert whatever statute of limitations they desire contrary to the plan's written provisions.

6. The dissenting opinion persuasively explains why the issues in this case are of national importance, why the court of appeal's decision will have widespread and damaging

repercussions, and why the decision is wrong. App. at 16a-26a. Rather than summarize that opinion here, Syed incorporates its points in his demonstration that this case warrants certiorari.

7. Since ERISA does not provide a statute of limitations for suits brought under § 502(a)(1)(B) to recover benefits, courts generally turn to the most analogous state statute of limitations. *See DelCostello v. International Bhd. of Teamsters*, 462 U.S. 151, 158-60 (1983). An overwhelming majority if not all other Circuits to address the issue has applied the statute of limitations for a state contract action. *See Harrison v. Digital Health Plan*, 183 F.3d 1235, 1239-40 (11th Cir. 1999); *Daill v. Sheet Metal Workers' Local 73 Pension Fund*, 100 F.3d 62, 65 (7th Cir. 1996); *Adamson v. Armco*, 44 F.3d 650, 652 (8th Cir. 1995); *Hogan v. Kraft Foods*, 969 F.2d 142, 145 (5th Cir. 1992); *Meade v. Pension Appeals & Review Comm.*, 966 F.2d 190, 195 (6th Cir. 1992); *Held v. Manufacturers Hanover Leasing Corp.*, 912 F.2d 1197, 1207 (10th Cir. 1990); *Pierce County Hotel Employees & Restaurant Employees Health Trust v. Elks Lodge*, 827 F.2d 1324, 1328 (9th Cir. 1987); *Dameron v. Sinai Hosp.*, 815 F.2d 975, 981 (4th Cir. 1987).

8. The Third Circuit is partially wrong in asserting that "Although this Circuit has not decided which state statute of limitations is applicable to ERISA § 502(a)(1)(B), every other circuit to address the issue has applied the statute of limitations for a state contract action." App. at 7a. Both Courts, The District Court of Delaware and The Third Circuit have previously decided this issue. *See Loving v. Pirelli Cable Corp.*, (3rd Cir. No. 95-7597 dated August 21, 1996). App. at 63a-64a. On March 29, 1995, the District Court of Delaware concluded that Loving claim for benefits under ERISA § 502(a)(1)(B) was time barred because of the applicable three-year statute of limitations. The Court applied 10 Del. C. § 8106 to Loving's claim. Although, the District Courts' decision in *Loving* dated March 29, 1995 was

not reported, it was cited by the Court in a related case. *See Loving v. Pirelli Cable Corp. et.al.*, 11 F. Supp.2d 480, 483, 484 (D.Del. 1998) as follows:

> "Count I claims that Loving "is entitled to benefits from the plan and VERP and makes a claim for benefits under ERISA Sec. 502(a)(1)(B), 29 U.S.C. Section 1132(a)(1)(B), as to both plans, which benefits were arbitrarily and capriciously denied to plaintiff."
>
> "At the oral argument the court stated that because the claims arise under ERISA, a federal statute without a built-in statute of limitations, it would look to state law for the proper limitations period. The court agreed that a three-year statute of limitations period applied."
>
> "On March 29, 1995, the court entered an order granting summary judgment in favor of the 1994 defendants on the ground that the 1994 complaint was time-barred by the applicable three year statute of limitations."

Loving, 11 F.Supp.2d at 483-484. Syed respectfully submits to this Court that *Mitchell v. E.I. DuPont de Nemours & Co.*, 310 A.2d 641, 642 (Del. 1973), relied on by the Third Circuit and the District Court in Syed's case but rejected by *Loving*, cannot be given any probative value in the presence of *Loving*. After all, State legislatures do not devise their limitations periods with national interests in mind, and it is the duty of the federal courts to assure that the importation of state law will not frustrate or interfere with the implementation of national policies. *Occidental Life Insurance Co. v. EEOC*, 432 U.S. 355,367 (1977).

9. *Mitchell v. E.I. DuPont de Nemours & Co.*, 310 A.2d 641, 642 (Del. 1973), a pre-ERISA case was also rejected in a later disability claim by the Delaware Superior Court. *See Shaw v. Aetna Life Ins. Co.*, 395 A.2d 384 (Del. Super, 1978). The Third Circuit rejected *Shaw* simply because the Court in that case did not elaborate why § 8111 should not apply. The Third Circuit commented ("Nonetheless, because the Shaw Court failed to explain why Section 8111 should not apply, we find Mitchell to be more persuasive.") . *See Vassallo v. Haber Elec. Co.*, 435 A.2d 1046, 1051 (Del. Super. 1981). *Vassallo* explained that Section 8111 is not applicable because "plaintiff is not entitled to journeyman's wages because of the employer's non-compliance with the statute." *Vassallo* utilized §8106 although the dispute was related to employer-employee relationship. Also *See Read v. Local Lodge 1284*, 528 F.2d 823 (3rd Cir. 1975). The Third Circuit in *Read* stated that "where a claim is for personal injuries, Delaware's two-year statute of limitations controls, regardless of the form the action takes." Syed's claim was filed within two years and should be considered timely filed.

10. Syed would urge this Court to consider the fact that his employment was terminated as of March 31, 1992. No employer-employee relationship existed between Syed and his employer after March 31, 1992. A promise was made to Syed on July 1, 1990 (the date the long term disability plan went into effect. See App. at 59a) that he would be provided long term disability benefits if he became disabled. Syed was provided disability benefits until March 31, 1994, and his cause of action did not arise until he received a letter on April 4, 1994 terminating his benefits. Syed respectfully submits that his claim is based on a promise and a statute (ERISA) and 10 Del. C. Section 8106 is controlling. Syed's cause of action did not arise almost four years after the promise was made and more than two years after his employment was terminated. It will be unfair if the plan

administrators were allowed to use a statute that deals with wages, overtime, and short term disability benefits which are not paid under an ERISA plan. *Mitchell* was such a case and the maximum duration of available benefits was six months. Syed's long term disability claim is valid until he reaches age 65. Mitchell's legal action was filed after the benefit-period had expired in contrast with the filing of Syed's action which was filed almost twenty years before the maximum benefit-period would expire.

11. Selecting the appropriate statute of limitations is a matter of federal, not state, law, and the task of a federal court is not to predict which statute of limitations the Delaware Supreme Court might select for an ERISA claim. Rather, "in borrowing the state statute of limitations to impose a time limitation on the federal cause of action, the federal court is `closing the gap' left by Congress in order to fashion a body of federal common law to supplement the federal statutory cause of action." *Harrison v. Digital Health Plan*, 183 F.3d 1235, 1238-39 (11th Cir. 1999). ERISA plans involve parties outside the employment relationship such as family members, the insurance company, and the plan administrator, and for that reason as well a § 502(a)(1)(B) claim does not fit squarely within § 8111. *See Harrison*, 183 F.3d at 1241-42 (noting that ERISA claims may involve non-work related injuries or illnesses and, thus, concluding that state breach of contract statute was more analogous to § 502(a)(1)(B) claims than workers compensation statute).

12. Syed submits to this Court that the most analogous state statute in Syed's case is found under State of Delaware's Workers' Compensation Act at 19 Del. C. § 2361 (b) which states:

> Where payments of compensation have been made in any case under an agreement approved by the Board or by an award of the

> Board, no statute of limitations shall take effect until the expiration of 5 years from the time of the making of the last payment for which a proper receipt has been filed with the Department.

19 Del. C. §2361 (b). App. at 78a. There is no dispute that Syed's disability resulted from his work injuries. The employer has agreed that Syed is partially disabled for life and continues to pay his medical expenses for work injuries.

13. Total disability is not even a requirement after a participant has been disabled for 6 months under the terms of the policy. A partial disability provision is included in the policy and both the District Court and the Third Circuit have ignored this claim. Neither Courts have made any determination on Syed's partial disability claim. The employer has accepted that Syed has been at least partially disabled for life under the State of Delaware's Workers' Compensation Act. The Federal Social Security administration has determined that Syed has been and continues to be totally disabled as of January 31, 1992. The employer's own medical expert states that Syed has been partially disabled. There has been no valid reason for Respondents not to grant Syed partial disability benefits available under the policy. This is a continuing violation of Syed's ERISA rights. *Dist. No. 15 Machinists' Fund v. Kahle Engr. Corp.* , 43 F.3d 852, 857-861 (3rd Cir. 1994) applies a statute of limitations in th context of each missed monthly payment under a plan to equate to a breach of contract with a separate cause of action for which a separate statute of limitations period arises to allow the breach to initiate a new cause of action for breach of contract. *Kahle* was cited with approval by this Court in *Bay Area Laundry Pension Fund v. Ferbar Corp.*, 522 U.S. 192, 118 S.Ct. 542, 139 L.Ed.2d 553 (1997). Under the rule, a plaintiff who does not sue in time to recover the first payment may still recover any succeeding

payments that come due within six years. *Kahle* was also grounded on *Jackson v. American Can Co.*, 485 F.Supp. 370 (W.D. Mich. 1980) wherein it was noted that a pension plan may qualify as an installment contract under which claims do not accrue until each payment comes due. While the Third Circuit has now applied Section 8111 to a wage claim, disability plan scenario, it is presumed that any claim in Delaware pursuant to and using the federal jurisdiction of ERISA to secure pension payments would fall under the reasoning of the Third Circuit, and would be asserted by any corporate or other employer seeking to deny payments from tax-qualified plans as well as from welfare plans funded by insurance contracts and administered by the claims departments of insurance companies.

14. One "of ERISA's purposes is to protect the financial integrity of pension and welfare plans by confining benefits to the terms of the plan as written." *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126, 128 (7th Cir. 1992) (Posner, J). ERISA's "written plan instrument" rule, one of ERISA's "core functional requirements," *Curtis-Wright Corp. v. Schoonejongen*, 514 U.S. 78, 84 (1995), assists in ensuring the nationally uniform administration of plans. It requires that all plan—self funded and insured alike—be in writing and be administered by fiduciaries "in accordance with" their written terms to the extent not inconsistent with ERISA. ERISA's exclusive civil enforcement provisions ensure the same goals, authorizing suit only if benefits are "due" under those written terms. ERISA § 502 (a)(1)(B), 29 U.S.C. § 1132 (a)(1)(B); *Pilot Life Ins. Co. v. Dedeaux, 481* U.S. 41, 52-57 (1987). It will be beneficial for all the Circuit Courts if there were a uniform national treatment of welfare benefits under ERISA § 502 (a)(1)(B). Congress did not intend for Delaware residents to have a one-year limitation period. "[i]mposing too short of a statute would interfere with the strong federal policy that underlies ERISA." *Hawii Carpenters Trust Funds v. Waiola Carpenter Shop, Inc.*, 823 F.2d 289, 298 (9th Cir. 1987).

This is particularly true in light of the three and six-year limitation periods provided in other parts of ERISA. See 29 U.S.C. § 1113. App. at 73a. Just across the river in the state of New Jersey (under the jurisdiction of Third Circuit), a six-year statute of limitations is applicable to a benefits claim under ERISA § 502 (a)(1)(B). *See Todish v. Cigna Corp.*, 206 F.3d 303 (3rd Circuit 2000) ("The parties agree that the New Jersey six-year statute of limitations for breach of contract claims applies to Todish's case, and . . . ").

III. THIRD CIRCUIT FAILED TO REALIZE THAT RESPONDENTS VIOLATED 29 U.S.C. § 1021(a), § 1024(b), § 1104(a), AND COMMITTED "FRAUD ON FEDERAL COURTS".

15. The Third Circuit has clearly made an error not of reasoning but of apprehension which has caused manifest injustice on the issues of Syed's claims under ERISA § § 502(c) and 503. Most of this has been caused by the Respondents fraudulent misrepresentations to the Third Circuit and the District Court of Delaware.

16. When Syed started his employment in September 1988, he was provided with portfolio as the plan document for short term and long term disability. On March 27, 1992, Syed met with his personnel manager who provided Syed with the same portfolio and advised him it was the plan document for disability benefits. On May 2, 1994, Syed requested in writing "I am requesting that Hercules Inc. provide me with an original brochure explaining Long Term Disability benefits in detail." A copy of portfolio was provided to Syed on July 20, 1994 by Mr. Patrick C. Donahue. This portfolio did not mention Provident Life and Accident Insurance Company as the claims fiduciary in it

pursuant to the statutory requirements of 29 U.S.C. § 1022(b). On February 24, 1995, Syed requested in writing ", . . . kindly forward to me a complete copy of LTD Plan document effective as of March 4, 1992." Again, a copy of portfolio was provided to Syed as the governing plan document by Patrick C. Donahue on March 22, 1995. App. at 65a. After consistently providing Syed with the portfolio between 1988 and 1995, the plan administrator has now asserted that a different document (SPD) was enforced as of July 1, 1990. See J. Douglas Hill's affidavit. App. 58a-60a at 59a. *See Epright,* 81 F.3d, 335, 339 (3rd Cir. 1996) citing *Snyder v. Titus,* 513 F. Supp. 926, 934 (E.D. Va.1981) ("[b]eing consistently wrong can hardly be sanctioned as right").

17. This same portfolio has been testified to as being the long term disability program of Hercules Inc. as of August 26, 1994. See Affidavit of Patrick C. Donahue. App. at 61a-62a. This portfolio was submitted to the Seventh Circuit and the United States District Court, Southern District of Indiana, Terre Haute Division, as Exhibit 1 of this affidavit in *Ramsey v. Hercules Inc., et.al.,* Cause No: TH93-215-C, and 77 F.3d 199 (7th Cir. 1996). Ramsey and Syed, both qualified under the same plan and under the same plan document. Ramsey's disability benefits were determined as of July 8, 1991 and were terminated as of July 7, 1993. Syed's benefits began on April 1, 1992 and terminated as of March 31, 1994. There is no doubt that the same ERISA plan document governed Syed's and Ramsey's benefits. Syed refers this Court to the sworn statements made by Mr. Patrick C. Donahue (Syed would also urge this Court to note that Mr. Donahue responded to Syed's request for a plan document on March 22, 1995 (App. at 65a), almost seven months after he submitted the affidavit on August 26, 1994):

> "Attached as Exhibit 1 to this affidavit is a true and exact copy of the Benefits Portfolio containing the Hercules Incorporated long

> term disability program applicable to Hercules employees, including Linda Ramsey."
>
> "I affirm under the penalties of perjury that the above and foregoing representations are true."

Affidavit of Patrick C. Donahue. App. at 61a-62a. After the arguments were completed in *Ramsey* on September 11, 1995 and the Seventh Circuit concluded on February 29, 1996 that this portfolio did not confer discretion on plan administrator with respect to long term disability benefits, Respondents have decided to use a different plan document in Syed's case. See Affidavit of J. Douglas Hill dated December 4, 1998. App. at 58a-60a. Syed was paid benefits under the terms of his ERISA plan (portfolio) which was in effect during 1992 and 1994. Respondents can not be allowed to switch plan documents after Seventh Circuit concluded that no discretion was granted to the administrator under the terms of the plan, then in effect.

18. Definition of total disability is completely different in the SPD and favors the Respondents. This explains why the Respondents have gone as far as trying to switch the plan document. The definition of total disability in portfolio states:

> You are considered totally disabled if you are not able to perform your job during the waiting period (normally six months) and during the first 24 months of benefit payments. You must not be able to engage in any work for wage or profit during this time, unless approved under the rehabilitative program.

> After receiving 24 monthly payments you are considered totally disabled for as long a you are prevented from performing any employment for wage or profit for which you are reasonably qualified by training, education, or experience.

Portfolio at page 8. There is no dispute that Syed was totally disabled from engaging "in any work for wage or profit during" the twenty-four (24) initial months of the benefit period. The dispute arose after the initial twenty four (24) month period when Hercules decided Syed was not totally disabled "from performing any employment for wage or profit." Syed submits the distinction between "engage in any work" and "performing any employment" is a semantical one at best. Regardless, Respondents have conceded that the Plan Administrator was not granted discretion under the plan to interpret the terms of the plan.

19. Respondents have conceded that Syeds' condition did not change after twenty four months and Syed has testified his condition has deteriorated. The portfolio also includes the following language:

> Fiduciaries are responsible for the operation of a Plan and must act solely in the interest of plan participants, and must exercise prudence in the performance of their duties.

Portfolio at page 12. If the plan fiduciary must act solely in the interest of plan participants then Syed is entitled to his long term disability benefits since Respondents have conceded that Syeds' condition did not change after the twenty four (24) months in which he was totally disabled. Respondents acted arbitrarily and capriciously in not providing Syed total or partial disability benefits available under the policy. Respondents acknowledge that Syed is

totally disabled in order to receive an offset for their counter-claim but refuse to acknowledge that Syed is at least partially disabled. See the District Court's decision in favor of Respondents. App. at 44a-46a. Respondents have breached their fiduciary duty under 29 U.S.C. § 1104 (a)(1)(D). App. at 73a.

20. If J. Douglas Hill's affidavit (App. at 58a-60a) is considered as true, then it is clear that Syed was not provided SPD in light of Patrick C. Donahue's affidavit (App. at 61a-62a) and considering the fact that Respondents consistently represented to Syed that portfolio was the plan document during 1988 and 1995. Syed can also produce several documents from Respondents affirming that the portfolio was the only document being used until 1995. Syed has also obtained "Brief of Defendants-Appellees Hercules Incorporated And Provident Life And Accident Insurance Company" dated May 15, 1995 submitted to the Seventh Circuit and affirming again that the portfolio submitted by Patrick C. Donahue was the applicable plan document. It should be clear to this Court that Mr. Donahue provided Syed with the same portfolio on March 22, 1995 in his letter. See App. at 65a. Again, since the plan year ran from July 1, 1994 to June 30, 1995, the portfolio was the only applicable document. SPD was not disclosed to Syed in violation of 29 U.S.C. Sections 1021(a), 1024(b), 1024(b)(1)(B), 1024(b)4, 1104(a)(1)(D), and 1132(c). A review of Department of Labor's file indicates that Respondents did not file either portfolio or SPD with the Department of Labor as required by 29 U.S.C. 1021(b). In 1998, Syed requested the United States Department of Labor to provide him with SPDs filed by Respondents during 1990 and 1998. Neither portfolio nor SPD was provided to Syed indicating those documents were never filed with the Department of Labor. If Respondents had followed the ERISA statutory requirements, Syed would have received the proper plan document soon after it went into effect as of July 1, 1990.

Syed's claim under ERISA § 502(c) and § 503 must be remanded to the District Court for a judgment in Syed's favor. Respondents did not quote the definition as it is contained in the portfolio thus violating ERISA § 503.

21. Two affidavits contradicting each other can not be true. Mr. Hill's affidavit is erroneous in light of Mr. Donahue's affidavit. Mr. Donahue's affidavit is erroneous in light of Mr. Hill's affidavit. If Mr. Donahue's affidavit was true, then it should be clear to this Court that Respondents have successfully defrauded the Third Circuit and the District Court of Delaware. This Court has previously concluded that fraud permits the reopening of a judgment. *See Hazel-Atlas Glass Co. v. Hartford Empire Co.*, 322 U.S. 238, 245-46, 64 S.Ct. 997, 1000-01, 88 L.Ed. 1250 (1944). *See Massachusetts Mut. Life ins. co. v. Russell*, 473 U.S. 134 (1985) (ERISA imposes "fiduciary and disclosure standards to guard against fraud and abuse of pension funds") (remarks of Rep. Brademas), reprinted in 3 Leg. Hist. 4694.

IV. SUMMARY JUDGMENT WAS NOT PROPER ON SYED'S § 502 (c) CALIM WHEN MATERIAL FACT WAS IN DISPUTE.

22. Summary Judgment is appropriate where admissible evidence fails to demonstrate a genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). Rule 56 requires summary judgment where a party "fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). In considering a motion for summary judgment, a

court does not resolve factual disputes or make credibility determinations and must view facts and inferences in the light most favorable to the non-moving party. *Siegal Transfer, Inc. v. Carrier Express, Inc.*, 54 F.3d 1125, 1127 (3d Cir. 1995).

23. The Third Circuit erred miserably in affirming the District Court's decision granting Summary judgment to Respondents on Syed's § 502 (c) claim. Both the District Court and the Third Circuit were made aware that Syed disputed that a proper SPD was not provided to him. See District Court's decision (App. at 32a, n.5) and Third Circuit's opinion (App. at 13a). Syed submitted Patrick C. Donahue's affidavit (App. at 61a-62a) and portfolio to both the District Court and with his Opening Brief On Appeal to the Third Circuit but the Third Circuit did not pay any attention to Syed's contention. Throughout his briefing to the District Court and the Third Circuit, Syed referred the Courts to the portfolio used in Ramsey case. Syed's briefing was done according to the portfolio provided to him as the plan document. It will be unfair if Syed's claim were decided based upon a document which was not the applicable plan document.

24. On April 1, 1999, two months prior to the District Court's decision in this case dated May 27, 1999, Syeds' attorney filed an "Application for amendment of complaint to add party" (App. at 51a-55a). Paragraphs 3 on page 4 of this application stated:

> The "Plan," SPD or whatever it may be termed was submitted by Affidavit of Patrick C. Donahue, Hercules Incorporated, and certified to under penalties of perjury on August 26, 1994 in the United States District Court, Southern District of Indiana, Terre Haute Division, as the Hercules Incorporated

long term disability program applicable to Hercules employees. See Appendix to Plaintiff's Reply Brief, at C1-C2.

App. at 54a. The sole basis for this application was that the portfolio (SPD) provided to Syed mentioned John Hancock Mutual Life Insurance Company, Policy Number 26701-GTC, as the insurance company and did not even mention Provident in it (App. at 54a). The District Court granted this application in an order dated July 14, 1999 (App. at 56a-57a), accepting Syeds' contention that the SPD submitted by Respondents to the the District Court and the Third Circuit as the governing plan document, was not provided to Syed. The SPD submitted by the Respondents to the Third Circuit does not mention John Hancock Mutual Life Insurance Company. Although , Syed represented to the Courts that an SPD was provided to him, he was referring to portfolio because this portfolio also mentions in it that it was a summary. It is clear from the record that Respondents have concealed portfolio from the federal courts in Syed's case after using it in *Ramsey , Supra.* The Third Circuit erred in not analyzing the documents submitted by Syed as the plan documents including the insurance policy. The Third Circuit has only analyzed the documents submitted by Respondents . The Third Circuit has made a mistake of apprehension and did not analyze the plan documents submitted by Syed. In his pleadings to the Third Circuit, Syed referred the Court to the insurance policy under which Syed's benefits were paid. Again, the Third Circuit made a mistake of not comparing the definition of total disability as it is found in the insurance policy. The definition states:

Total Disability and Totally Disabled
You will be termed Totally Disabled due to injury or illness only if you are not able to work at any job for gain or profit for which

you are fitted by education, training, or experience.

Policy M-462-LTD at page 5. Syed submits to this Court that this definition does not have two tiers. Syed qualified under this definition but the Third Circuit failed to analyze this definition and actually caused Syed prejudiced by commenting "thus belying Syed's assertion that the two-tier definition of disability did not exist in the SPD, . . ." (App. at 13a). Respondents have defrauded the federal courts and the Third Circuit has failed its duty to detect this fraud despite the fact that contradicting affidavits submitted by the Respondents are in the record. The District Court and the Third Circuit solely relied on erroneous affidavit submitted by J. Douglas Hill (App. at 58a-60a) and ignoring Syed's pleadings in order to dismiss Syed's claim under § 502 (c) and § 503.

V. THE THIRD CIRCUIT ERRED IN IGNORING THE INSURANCE POLICY WHICH MEETS ALL THE STATUTORY REQUIREMENTS OF ERISA AND 29 U.S.C. § 1022 (b).

25. 29 U.S.C. § 1022 (b) requires that the plan description and SPD contain the source of financing of the plan and the identity of any organization through which benefits are provided. Both the SPD and the LTD plan submitted by the Respondents and accepted by the District Court and the Third Circuit, indicate Policy No. M-462-LTD-ASO as the funding policy. Syed submits to this Court that both these documents are faulty and can not be given any probative value since Syed's benefits were paid under Policy No. M-462-LTD which went into effect as of July 1, 1990. See Social Security Reimbursement Agreement signed by Syed on

November 13, 1992 indicating M-462-LTD as the insurance policy. (App. at 66a-67a). Letters provided to Syed by Provident Life and Accident Insurance Co., Claims Fiduciary, also indicate Policy No. M-462-LTD. A review of Forms 5500 filed by the Respondent with IRS for 1991 through 1997, which are a matter of public record, indicate that Policy M-462-LTD is listed as the insurance policy. J. Douglas Hill's affidavit affirms that this policy is the funding mechanism for the Plan. (App. at 59a). The SPD and LTD submitted by Respondents were not executed until October 1995, and can not be considered for Syed's claim because Syed's benefits were terminated as of April 1, 1994. Both the SPD and LTD, considered by the Third Circuit are in violation of § 1022 (b) and it was a legal error for the Third Circuit to solely rely on these documents.

26. The only document which meets all the statutory requirements of § 1022 (b) is the insurance policy which was not disclosed to Syed until March 25, 1997. This policy does have an effective date of July 1, 1990 and informs a participant about ERISA's requirements. This policy needed to be disclosed to Syed soon after it went into effect on July 1, 1990. See the agreement signed by Syed on November 13, 1992 at App. 67a stating "I hereby acknowledge the limitations and provisions as stated in the booklet certificate of this plan." Syed submits to this Court that the language and text of this agreement came out of Policy No. M-462-LTD and it is clear that this policy is the governing plan under which the benefits were paid. Syed also submits that this policy is the governing plan document particularly because Respondent did not have a legal plan document during 1990 and 1995. The SPD and LTD submitted by Respondents do not contain a provision that a participant must sign a reimbursement agreement as does the insurance policy. This policy also contains a section "Enrolling in the Plan." Syed questions the need for a participant to enroll in an insurance policy if indeed this document is an insurance

policy between Provident and Respondents. Interestingly, the cover of this document states "Your Long Term Disability Benefit, Hercules Incorporated" and throughout this document references are made to this policy being the "plan".

27. The District Court and the Third Circuit are completely wrong in rejecting Syed's contention that this insurance policy is the plan document. Both Courts have based their conclusion relying upon an erroneous affidavit submitted by J. Douglas Hill. Syed has produced evidence that Hill's affidavit is false in light of Donahue's affidavit on the issue of which plan document was in effect as of July 1, 1990. Hill's affidavit is also erroneous because he states that this insurance policy was not issued until February 21, 1994. (App. at 59a). Syed refers this Court to the agreement signed on November 13, 1992 at App. 66a. Syed was paid benefits out of this policy as of April 1, 1992 and Respondent advised the IRS that M-462-LTD was enforced as of July 1, 1990. Syed has demonstrated that Hill's affidavit is factually wrong and erroneous on this issue as well. The Third Circuit erred in accepting Hill's erroneous affidavit as being true and not paying any attention to Syed's contentions. This case must be remanded to the District Court so Syed will have an opportunity to cross-examine the witnesses representing the Respondents. Use of an insurance policy issued by an insurance company has been determined to comprise an employee benefit plan of an employer in the following jurisdictions:

Medoy v. Warnaco Disability Plan, 43 F.Supp.2d 303, 305 (E.D.N.Y. 1999); *Hughes v. Boston Mutual Life Ins. Co.*, 26 F.3d 264, 266 (1st Cir. 1994); *Kunstenaar v. Conn. Gen. Life Ins.* Co. 902 F.2d 181 (2d Cir. 1990); *Reinking v. Philadelphia Am. Life Ins. Co.* 910 F.2d 1210, 1213-1214 (4th. Cir. 1990); *Godwin v. Sunlife Assur. Co. of Canada*, 980 F.2d 323,324 (5th Cir. 1992); *Rowan v. UNUM*, 119 F.3d 433,434 (6th. Cir 1997); *Ladd v. ITT*

Corp., Metlife, 148 F.3d 753 (7th. Cir. 1998); *Johnson v. State Mutual Life Assur. Co. of America,* 942 F.2d 1260,1262 (8th Cir. 1991); *Mongeluzo v. Baxter Travenol Disability Ben. Plan,* 46 F.3d 938, 940 (9th Cir. 1995); *Riley v. UNUM,* 28 F. Supp.2d 639, 640 (D.Kan.1998).

VI. THE THIRD CIRCUIT DENIED SYED DUE PROCESS OF LAW IN IGNORING HIS PLEADINGS.

28. The Third Circuit virtually relied totally on the Respondents' pleadings and ignored petitioner's complaint and pleadings. In particular Syed refers this Court to Third Circuit's comments about SPD and LTD. (App. at 13a). Respondent's reproduced the SPD in the form of LTD and added more discretionary language in it. Third Circuit basically failed to analyze the insurance policy which Syed has asserted to be the plan document. See previous section V. The Third Circuit failed to analyze either the portfolio or the insurance policy submitted by Syed as the plan documents. It is both unfair and denial of due process if a reviewing court does not pay any attention to the pleadings of one party. Respondent's skillful but misleading and fraudulent litigation has induced the Third Circuit to ignore Syed's pleadings. The very same SPD that Third Circuit has analyzed also contains a provision for partial disability. Total disability is not even a requirement under the terms of this SPD after a participant has been disabled for six months. Syed's complaint asserted a claim for partial disability which has been ignored by the District Court and the Third Circuit. Third Circuit is wrong in saying:

> Because Syed was under 62 when he started receiving benefits, he was eligible to receive benefits for as long as he remained totally disabled, up to age 65. See *id.* at B22.

App. at 3a. Third Circuit and the District Court ignored the partial disability provision in the SPD. The definition quoted by the Third Circuit does not belong in the portfolio. Respondents have illegally modified this definition. Syed continues to receive Social Security Disability Benefits and has been declared partially disabled by the employer under the Workers' Compensation Act of the State of Delaware. Respondents want to ignore the medical basis for Syed's disability, but want the financial benefit of the Award of Social Security Disability to offset a plan benefit. See App. at 44a-46a.

29. Syed submits to this Court that his constitutional rights under Fifth Amendment and 42 U.S.C. § 1983 (App. at 75a) have been violated because Third Circuit and the District Court did not pay any attention to his contentions. It will be unfair if a legal action was decided on the basis of a contract which a party did not even acknowledge to be the true contract between the parties. Respondents consistently advised Syed that a different contract (portfolio) was applicable.

> "The fundamental requirement of due process is the opportunity to be heard `at a meaningful time and in a meaningful manner.' " *Mathews v. Eldridge*, 424 U.S. 319, 333, 96 S. Ct. 893, 902 (1976) (quoting *Armstrong v. Manzo*, 380 U.S. 545, 552, 85 S. Ct. 1187, 1191 (1965)).

Syed submit to this Court that his case was not heard in a meaningful manner because his pleadings were based on portfolio which has been ignored. This is contrary to what Congress intended for ERISA participants. Syed urges this Court that this case should be remanded back to the District

Court to determine the very basic question in this case as to which document was applicable during 1992 and 1994.

CONCLUSION

For the foregoing reasons, petitioner urges the Court to grant a writ of certiorari in this case.

Respectfully submitted,

Sajid L. Syed
Pro se
3805 Eunice Ave.
Wilmington, DE 19808
(302) 999-9066

December 4, 2000

APPENDIX TABLE OF CONTENTS

	Page
Appendix A- Opinion of the Court of Appeals, filed May 30, 2000	1a
Appendix B- Order of the Court of Appeals, denying Petition for Rehearing, with Suggestion for Rehearing en Banc, filed July 10, 2000.....	27a
Appendix C- Order of the District Court granting Summary Judgment, filed May 28, 1999	29a
Appendix D- Order of the District Court denying Motion for Reconsideration , filed July 14, 1999	47a
Appendix E- Application to Add Party filed April 1, 1999	51a
Appendix F- Order of the District Court granting Application to Add Party, filed July 14, 1999	56a
Appendix G- Affidavit of J. Douglas Hill dated December 4, 1998	58a
Appendix H- Affidavit of Patrick C. Donahue dated August 26, 1994	61a
Appendix I- Order of the Court of Appeals from *Loving v. Pirelli Cable Corp.* (3d Circuit No. 95-7597), dated August 21, 1996	63a
Letter from Patrick C. Donahue dated March 22, 1995	65a
Appendix K- Social Security Reimbursement Agreement dated November 13, 1992	66a

APPENDIX TABLE OF CONTENTS

	Page
Statutory, Regulatory, and Constitutional provisions Involved	68a
29 U.S.C. § 1002 (1). Definitions	68a
29 U.S.C. § 1002 (21)(A). Definitions	68a
29 U.S.C. § 1021(a). Duty of disclosure and reporting	69a
29 U.S.C. § 1022. Summary plan description	69a
29 U.S.C. § 1024(b). Filing and furnishing of information	70a
29 U.S.C. § 1024 (b) (4).....	72a
29 U.S.C. § 1102 (a)(1). Establishment of plan	72a
29 U.S.C. § 1104 (a)(1)D)	73a
29 U.S.C. § 1113. Limitation of actions	73a
29 U.S.C. § 1132 (a)(1)(B), ERISA § 502 (a)(1)(B).....	73a
29 U.S.C. § 1132 (c)(1) , ERISA § 502 (c)(1)	74a
29 U.S.C. § 1133 , ERISA § 503	74a
42 U.S.C. § 1983. Civil action for deprivation of rights	75a
U.S. CONSTITUTION : FIFTH AMENDMENT	75a
29 C.F.R. § 2520.102-3(q)	76a
10 Del. C. § 8106. Actions subject to 3-year limitation	77a
10 Del. C. § 8111. Work, labor or personal services ...	77a
10 Del. C. § 8119. Personal injuries	78a
18 Del. C. § 3914. Notice of statute of limitations.....	78a
19 Del. C. § 2361 (b). Limitation periods for claims ...	78a

APPENDIX A

Filed May 30, 2000

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 99-5472

SAJID L. SYED
Appellant

v.

HERCULES INC., a Delaware corporation; HERCULES INCORPORATED INCOME PROTECTION PLAN, an employee welfare benefit plan; HERCULES INCORPORATED, Plan Administrator of Disability Plan

---

ON APPEAL FROM THE
UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

(Dist. Court No. 96-62)
District Court Judge: Joseph J. Farnan, Jr., C.J.

Argued January 11, 2000
Before: BECKER, *Chief Judge*, and ALITO and BARRY, *Circuit Judges*.

(Opinion Filed: May 30, 2000)

John M. Stull, Esq. (Argued)
1220 North Market St., Ste. 510
P.O. Box 1947
Wilmington, DE 19899

Counsel for Appellant

Kevin R. Shannon (Argued)
Potter, Anderson & Corroon, LLP
1313 N. Market St.
P.O. Box 951
Wilmington, DE 19899

Counsel for Appellee

OPINION OF THE COURT

ALITO, *Circuit Judge*:

Sajid Syed ("Syed") injured his back in January 1992, while working as a chemical operator for Hercules, Inc. ("Hercules"). Syed brought this action under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), alleging that Hercules denied him disability benefits owed under the company's employee benefits plan. In addition to damages, Syed requested the imposition of sanctions against Hercules for failure to provide him with the plan document pursuant to a written request, as required by ERISA § 502(c), 29 U.S.C. § 1132(c). He also sought redress for Hercules's failure to give him adequate written notice of the reasons for the denial of his claim, as required by ERISA § 503, 29 U.S.C. §

1133. Syed appeals the District Court's grant of summary judgment in favor of Hercules on all counts. We affirm.

Hercules discharged Syed on March 4, 1992, effective March 31, 1992, as part of a reduction in force. Following his termination, Syed submitted a claim for long-term disability benefits under the Hercules Incorporated Income Protection Plan (the "Plan"). His claim was approved on June 18, 1993, and Syed began receiving benefits retroactive to April 1, 1992.

Benefits are payable under the Plan when a worker becomes totally disabled and remains disabled for six consecutive months.[1] See App. at B21. Because Syed was under 62 when he started receiving benefits, he was eligible to receive benefits for as long as he remained totally disabled, up to age 65. See *id.* at B22. The Plan provides two definitions of total disability, one that applies for the first 24 months after the "elimination period" and another that applies thereafter. The Plan states:

> During the elimination period, normally 6 months, and the first 24 months of benefit payments, you are considered totally disabled if you are not able to perform your job. You must not engage in any work for wages or profit during this time.
>
> After receiving 24 monthly payments, you are considered totally disabled for as long as you are not able to engage in any employment for wage or profit for which you are reasonably qualified by training, education, or experience.

---

[1] This six-month period, known as the "elimination period," was apparently not imposed by Provident in Syed's case. He began receiving benefits less than three months after his workplace accident.

App. at B24.

After paying benefits to Syed for almost two years, Provident Life and Accident Insurance Co. ("Provident"), the Claims Fiduciary under the Plan, asked Syed to undergo an independent medical evaluation in February 1994 to determine if he was totally disabled under the latter definition. Dr. Joson, who performed the examination in March 1994, reported that Syed could not do heavy work, but that he could do "sedentary to light" work. App. at A4. Because Syed would no longer qualify for benefits after the 24-month period lapsed, Provident notified Syed that his benefits would be terminated as of March 31, 1994. *See id.* at A6-7.

Syed appealed the decision to terminate his disability benefits to Provident's ERISA Committee, which upheld its previous decision. See App. at A19-20. Syed renewed his appeal to the ERISA Committee on July 27 and October 28, 1994, each time including updated medical reports. The ERISA Committee sent its final denial of benefits to Syed by letter dated November 9, 1994. On February 24, 1995, Syed requested a copy of the plan document that was effective as of the date he began receiving benefits. Hercules sent him a document entitled "Summary Plan Description" (SPD). App. at B15-32.

Syed filed suit on February 6, 1996 – one year and eleven months after the initial denial of benefits on March 31, 1994, and one year and three months after the final letter from Provident dated November 9, 1994. Shortly thereafter, he filed a motion for summary judgment seeking recovery of benefits under ERISA § 502(a)(1)(B), sanctions under § 502(c) for failure to produce the Plan document in response to a written request, and a remedy under § 503 for failure to provide written notice of the reasons for termination

of benefits. Hercules made a cross-motion for summary judgment, claiming that Syed owed money for overpayments made under the Plan.

The District Court denied Syed's motion. As the Plan gave the Claims Fiduciary the exclusive discretion to deny claims for benefits, the District Court reviewed Syed's § 502(a)(1)(B) claim under the abuse of discretion standard in accordance with *Firestone Tire and Rubber Co. v. Bruch*, 489 U.S. 101, 115 (1989); *see also Abnathya v. Hoffman-La Roche, Inc.*, 2F.3d 40, 45 (3d Cir. 1993). After reviewing the medical evidence, the District Court found that there was a genuine issue as to whether Provident acted arbitrarily and capriciously in terminating Syed's medical benefits. Nonetheless, after borrowing Delaware's one-year statute of limitations applicable to claims for "other benefits arising from . . . work, labor or personal services performed," 10 Del. C. § 8111, the Court granted summary judgment for Hercules on this claim.

Next, the Court dismissed Syed's § 502(c) claim. ERISA § 502(c) provides that an administrator must comply with a request for information by a plan participant and imposes personal liability for failure to do so. Syed contended that Hercules improperly sent him the SPD, rather than the Insurance Policy, see App. at B60, in response to his request. However, the Court held that the SPD was the operative plan document for the relevant time period and therefore granted summary judgment in favor of Hercules on this count. Likewise, the Court refused to remand Syed's case to the plan administrator for an out-of-time administrative appeal for the alleged violation of ERISA § 503, because Hercules's March 31 letter adequately set forth the reasons for denying Syed's benefits.

Syed makes four arguments on appeal. First, he contends that his ERISA claim for employee benefits should be

governed by Delaware's three-year statute of limitations for contract actions, not the one-year statute for claims arising out of work, labor, or personal services performed. Second, he maintains that Hercules, as Plan Administrator, should be subject to sanctions for failing to provide proper disclosure as required by ERISA § 502(c). Third, Syed argues that Hercules violated ERISA § 503 both by failing to provide specific reasons for the denial of his claim and by neglecting to name any additional material or information that would have helped him perfect his claim. Finally, Syed asserts that the District Court should have exercised plenary review over the Claims Fiduciary's decision to deny his benefits, rather than reviewing for an abuse of discretion, as the Plan did not grant discretion to the Claims Fiduciary to make a disability determination. Because we hold that Delaware's one-year statute of limitations governs this action, we affirm the District Court's grant of summary judgment on Syed's § 502 (a)(1)(B) claim without deciding whether Provident's decision to deny Syed's benefits was arbitrary and capricious. We likewise affirm the District Court's dismissal of Syed's claims under ERISA §§ 502(c) and 503.

ERISA § 502(a)(1)(B): Statute of Limitations

The chief issue in this appeal concerns the statute of limitations that is applicable to Syed's claim for benefits under ERISA § 502(a)(1)(B).[2] Unfortunately, ERISA does not provide a statute of limitations for suits brought under § 502(a)(1)(B) to recover benefits, and the new, general federal statute of limitations set out in 28 U.S.C. § 1658 does not

[2] We exercise plenary review over the District Court's choice of the applicable statute of limitations. *See Nelson v. County of Allegheny*, 60 F.3d 1010, 1013 (3d Cir. 1995).

apply in this situation.[3] Under these circumstances, courts generally turn to the most analogous state statute of limitations. *See DelCostello v. International Bhd. of Teamsters*, 462 U.S. 151, 158-60 (1983). Although this Circuit has not decided which state statute of limitations is applicable to ERISA § 502(a)(1)(B),[4] every other circuit to address the issue has applied the statute of limitations for a state contract action. *See Harrison v. Digital Health Plan*, 183 F.3d 1235, 1239-40 (11th Cir. 1999); *Daill v. Sheet Metal Workers' Local 73 Pension Fund*, 100 F.3d 62, 65 (7th Cir. 1996); *Adamson v. Armco*, 44 F.3d 650, 652 (8th Cir. 1995); *Hogan v. Kraft Foods*, 969 F.2d 142, 145 (5th Cir. 1992); *Meade v. Pension Appeals & Review Comm.*, 966 F.2d 190, 195 (6th Cir. 1992); *Held v. Manufacturers Hanover Leasing Corp.*, 912 F.2d 1197, 1207 (10th Cir. 1990); *Pierce County Hotel Employees & Restaurant Employees Health Trust v. Elks Lodge*, 827 F.2d 1324, 1328 (9th Cir. 1987); *Dameron v. Sinai Hosp.*, 815 F.2d 975, 981 (4th Cir. 1987). Because Delaware, in essence, has two statutes of limitation for contract disputes, however, we must determine which is more appropriate.

Delaware Code § 8106 establishes a three-year statute of limitations for general actions on a promise. *See Goldman v. Braunstein's, Inc.*, 240 A.2d 577, 578 (Del. 1968). Section 8106 provides:

---

[3] This provision, which prescribes a four-year limitations period, applies only to claims arising under acts of Congress enacted after December 1,1990. ERISA was enacted much earlier.

[4] We have previously suggested in dicta that the New Jersey state statute of limitations for a contract action would apply to claims under ERISA § 502(a) (1)(B), but we have never squarely decided the issue. *See Connell v. Trustees of the Pension Fund of the Ironworkers Dist. Council of N. New Jersey*, 118 F.3d 154, 156 n.4 (3d Cir. 1997).

> No action to recover damages for trespass, no action to regain possession of personal chattels, . . . no action based on a promise, . . . shall be brought after the expiration of 3 years from the accruing of the cause of such action.

Del. Code Ann. tit. 10, § 8106 (emphasis added). Delaware also has a more specific statute of limitations covering employment disputes, § 8111, which provides:

> No action for recovery upon a claim of wages, salary, or overtime for work, labor or personal services performed, . . . or for any other benefits arising from such work, labor or personal services performed . . . shall be brought after the expiration of one year from the accruing of the cause of action on which such action is based.

Del. Code Ann. tit. 10, § 8111 (emphasis added). In this case, the District Court applied § 8111, relying on *Mitchell v. E.I. DuPont de Nemours & Co.*, 310 A.2d 641, 642 (Del. 1973).

In *Mitchell*, the Delaware Supreme Court applied § 8110 (now § 8111) to a claim challenging the denial of benefits under a disability wage plan. *See Mitchell*, 310 A.2d at 642. The Court reasoned that the plan at issue was a "benefit" arising from work, labor, or services performed within the meaning of the statute because eligibility for the plan accrued from tenure on the job. *See id.* Although the District Court in the present case mistakenly referred to *Mitchell* as an ERISA case (*Mitchell* was decided in 1973 and ERISA was not effective until 1974), the application of § 8111's predecessor in the pre-ERISA context is strong evidence of its close relationship to the ERISA claim that Syed asserts. *See also Sorenson v. Overland Corp.*, 142 F. Supp. 354, 360 (D. Del. 1956) ("The one year statute has a comprehensive sweep. It was intended to bar all claims arising out of the

employer-employee relationship. The Act bars claims for `wages', `salary', and it likewise applies to `overtime' and to any other `benefits' arising from the corporate-officer employment relationship. The word `benefits' is embracing and covers all advantages growing out of the employment.").

The Eighth Circuit dealt with a similar issue in *Adamson v. Armco*, 44 F.3d 650 (8th Cir. 1995). There, the Court had to choose between Minnesota's six-year statute of limitations governing general contract disputes and the state's two-year statute of limitations for wage claims. The Court reasoned that the wage-claim statute of limitations was the most analogous to the appellant's § 502(a)(1)(b) claim because Minnesota courts had uniformly applied that statute broadly to cover all damages arising out of the employment relationship. *See Adamson*, 44 F.3d at 652. In support of its conclusion, the Court noted that pre-ERISA case law in Minnesota had applied the two-year statute of limitations to cases of unpaid benefits. *See id.* (citing *Kohout v. Shakopee Foundry Co.*, 162 N.W.2d 237 (Minn. 1968)).

Syed relies primarily on two cases to bolster his argument for application of § 8106: *Rich v. Zeneca, Inc.*, 845 F. Supp. 162 (D. Del. 1994) and *Shaw v. Aetna Life Insurance Co.*, 395 A.2d 384 (Del. Super. Ct. 1978). *Rich* held that § 8106 should apply to a claim under ERISA § 510, 29 U.S.C. § 1140, for wrongful termination based on a pension-defeating motive. *See Rich*, 845 F. Supp. at 166 (citing *Goldman v. Braunstein, Inc.*, 240 A.2d 577 (Del. 1968)). The *Rich* Court chose § 8106 rather than § 8111 because the latter applies to claims for breach of a promise to pay something already earned, whereas the former applies to claims for breach of a promise to pay what would have been earned had employment continued. *See id.* Since Syed's disability benefits were already "earned" through his period of

employment at Hercules, *Rich* does not support the argument that § 8106 should apply here.

In *Shaw*, the Delaware Superior Court refused to apply § 8111 where an employee brought an action under the employer's voluntary group accident insurance policy. *Shaw*, 395 A.2d at 385. The employee was injured in a workplace injury which resulted in his permanent and total disability. The employer argued that § 8111 should apply to the claim because coverage under the policy arose out of the employment relationship. *See id.* at 387 (relying on *Mitchell*). The Court dismissed defendant's argument summarily. *See id.* ("That contention of the defendant is without merit."). Instead, the Court applied Delaware's two-year statute of limitations for personal injury claims. *Del. Code* § 8119. It is not immediately clear how Shaw is distinguishable from Syed's case, and Hercules has not pointed out any meaningful distinction. Nonetheless, because the *Shaw* Court failed to explain why § 8111 should not apply, we find *Mitchell* to be more persuasive.

Although Syed's § 502(a)(1)(B) claim comes within Delaware's more specific statute of limitations for claims arising out of the employer-employee relationship, that does not conclusively resolve the issue. After all, the selection of an appropriate statute of limitations is a question of federal law. *See United Auto Workers v. Hoosier*, 383 U.S. 696, 706 (1966).

Generally, we presume that Congress intended courts to apply the most closely analogous state statute of limitations. *See DelCostello*, 462 U.S. at 158. This principle rests on the assumption that "Congress would likely intend that courts follow their previous practice of borrowing state statutes." *Id.* at 158-59 n.12. We remain mindful of the Supreme Court's warning not to apply state statutes of limitation mechanically since "[s]tate legislatures do not

devise their limitations periods with national interests in mind, and it is the duty of the federal courts to assure that the importation of state law will not frustrate or interfere with the implementation of national policies." *Occidental Life Ins. Co. v. EEOC*, 432 U.S. 355, 367 (1977). Nonetheless, there is no reason to reject the state statute unless we find it "inconsistent with national labor policy." *Auto Workers*, 383 U.S. at 706.

In this case, we recognize that the one-year statute of limitations of § 8111 is short, but we cannot say that it is inconsistent with the policy of ERISA. We therefore agree with the District Court that Syed's claim was governed by § 8111 and was thus barred.

We are not persuaded by the arguments advanced by the dissent in support of its position that Syed's claim for disability benefits is more analogous to an ordinary contract claim, subject to § 8106, than to a claim for "other benefits arising from . . . work, labor or personal services," subject to § 8111. Noting that the Mitchell court described the plan at issue there as providing a "fringe benefit," the dissent argues that "Syed's claim . . . has little or nothing to do with work or services performed or fringe benefits . . . .," Dissent at 15, but this is simply not true. First, Syed's claim was squarely based on his prior employment. In order to qualify under the long term disability plan, he had to be "a regular, full-time non-represented employee of the Company . . . ." Appendix to Answering Brief at B20 (Summary Plan Description). Second, ERISA benefits are often termed "fringe benefits." *See, e.g., Bricklayers and Allied Craftsmen Int'l Union Local 33 Benefit Funds v. America's Marble Source, Inc.*, 950 F.2d 114, 118 (3d Cir. 1991).[5] We are inclined to

[5] We also note that Delaware's Wage Payment and Collection Act (WPCA), *Del. Code Ann.* tit. 19, §§ 1101-1115, defines "benefits" as "compensation for employment other than wages, including, but

agree with the dissent that the one-year limitations period of § 8111 is not optimal, and we also believe that a uniform, national statute of limitations for claims such as Syed's would be beneficial. But forced to identify the most analogous Delaware statute of limitations, we agree with the District Court that § 8111 is the best fit.[6]

ERISA § 502(c)

Syed urges the Court to impose sanctions on Hercules for failing to provide the Plan document pursuant to a written request. ERISA § 502(c) provides that a plan administrator must comply with a request for information from a plan participant within 30 days or face personal liability, at the Court's discretion, of $100 a day from the date of the refusal. 29 U.S.C. § 1132(c). The District Court did not abuse its discretion in refusing to order sanctions against Hercules, and we affirm the grant of summary judgment on this issue.

---

not limited to, reimbursement for expenses, health, welfare or retirement benefits . . . ." *Del. Code Ann.* tit. 19, § 1109(b). Although the WPCA does not provide a statutory remedy for the denial of benefits, its definition quite clearly encompasses the disability benefits Syed has sued to recover here.

[6] In view of the dissent's reference (Dissent footnote 3) to the Pennsylvania Wage Payment and Collection Law, 43 P.S. § 260.1 *et seq.*, which has a three-year statute, *see* 43 Pa. Cons. Stat. Ann. § 260.9a(g), we wish to make it clear that we express no view regarding the statute of imitations that would apply if a claim such as Syed's were brought in Pennsylvania. We note, however, that we have held that some ERISA claims are governed by the WCPL's statute of limitations and others are not. *See Gluck v. Unisys Corp.*, 960 F.2d 1168, 1180-81 (3d Cir. 1992).

Hercules sent Syed the SPD on March 22, 1995, in response to his February 24, 1995, written request for "a complete copy of LTD Plan document effective as of March 4, 1992." App. at A28. Syed contends that a different document was in effect at the time he was injured and at the time his benefits were denied. Specifically, he points to the insurance policy used to fund Hercules's long-term disability plan (LTD). App. at B35-72.

A comparison of the SPD and LTD reveals no material differences between the two documents. Syed complains that he was not able to verify "whether the definition of disability is based on official plan language, SPD language,or some internal policy, written or unwritten." Appellant's Br. at 20. This argument lacks merit. For example, the March 31, 1994, letter denying Syed's benefits, see App. at A6, quotes the definition of total disability found at page 8 of the SPD, see App. at B24. This definition is exactly the same as the definition of total disability found on page 3 of the LTD, see App. at B43, thus belying Syed's assertion that the two-tier definition of disability did not exist in the SPD, see Appellant's Br. at 22. The affidavit of Douglas Hill, Director of Employee Benefits for Hercules, makes clear that the document Hercules allegedly refused to send to Syed pursuant to his March 1995 request was, in fact, not executed until October 1995 (although it was effective retroactively to July 1990). Because the SPD and the LTD are identical in all respects material to this dispute, the District Court properly refused to impose sanctions against Hercules under ERISA § 502(c), 29 U.S.C. § 1132(c).

ERISA § 503

ERISA § 503 provides, in pertinent part, that every employee benefit plan shall:

> provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant.

29 U.S.C. § 1133(1). Pursuant to this section, the Secretary of Labor has established that written notice of denial of a claim must:

> provide to every claimant who has been denied a claim for benefits written notice setting forth in a manner calculated to be understood by the claimant:
>
> (1) The specific reason or reasons for the denial;
>
> (2) Specific reference to pertinent plan provisions on which the denial is based;
>
> (3) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and
>
> (4) Appropriate information as to the steps to be taken if the participant or beneficiary wishes to submit his or her claim for review.

29 C.F.R. § 2560.503-1(f).

We have previously held that § 503 sets forth only the disclosure obligations of "the Plan" and that it does not establish that those obligations are enforceable through the sanctions of § 502(c). *See Groves v. Modified Retirement Plan*, 803 F.2d 109, 118 (3d Cir. 1986). Where a termination letter does not comply with the statutory and regulatory requirements, the time limits for bringing an

administrative appeal are not enforced against the claimant. *See Epright v. Environmental Resources Management, Inc. Health and Welfare Plan*, 81 F.3d 335, 342 (3d Cir. 1996). Thus, the remedy for a violation of § 503 is to remand to the plan administrator so the claimant gets the benefit of a full and fair review. *See Weaver v. Phoenix Home Life Mut. Ins. Co.*, 990 F.2d 154, 159 (4th Cir. 1993).

The March 31, 1994, letter from Provident to Syed began with a quotation from the Plan's definition of total disability. *See* App. at A6. Next, the letter explained that Syed's benefits were being terminated because the results of Dr. Joson's independent medical evaluation demonstrated that Syed was no longer totally disabled as the term was defined in the Plan. *See* App. at A6-7. The letter went on to identify several jobs for which Syed would be qualified given his present physical condition. *See* App. at A7. Provident stated that Syed could submit a request for reconsideration of the decision, accompanied by documents from Syed's physician. *See id.* Lastly, the letter noted that any information to be considered in connection with an appeal would have to be received within 60 days of Syed's receipt of the letter. *See id.* In short, Provident fully complied with the statutory and regulatory requirements for notice under ERISA § 503, and Syed has not raised any genuine issue of material fact to the contrary. Accordingly, we affirm the District Court's grant of summary judgment as to Syed's claim under ERISA § 503, 29 U.S.C. § 1133.

BARRY, Circuit Judge, concurring and dissenting.

While I agree with much of the majority's opinion, I cannot agree with the conclusion that the most analogous state statute of limitations for a § 502(a)(1)(B) claim is found in Delaware's § 8111. It is on that issue, and that issue alone, that I dissent.

First, it is clear, as the majority notes, that every circuit which has addressed this issue has applied the statute of limitations for a state contract action as most analogous to an ERISA claim for the denial of benefits. As the majority also notes, we, too, have suggested, albeit in *dicta*, that the state statute of limitations for a contract action would apply to claims under § 502(a)(1)(B). *See Connell v. Trustees of the Pension Fund of the Ironworkers Dist. Council of Northern New Jersey*, 118 F.3d 154, 156 n.4 (3d Cir. 1997). Moreover, district courts too numerous to mention have also concluded that a state contract statute of limitations is most analogous to a § 502(a)(1)(B) claim. This is, indeed, a resounding chorus.

The rub here, however, is this. The majority concludes that "Delaware, in essence, has two statutes of limitation for contract disputes," specifically § 8106 and § 8111, and one, of course, must be selected. The majority then selects § 8111, which relates to claims "for wages, salary, or overtime for work, labor or personal services performed . . . or for any other benefits arising from such work, labor or personal services" as being "more specific" and, thus, most analogous to a claim for denied disability benefits under ERISA than § 8106, the statute traditionally used in Delaware for breach of contract, or breach of promise, actions. While I agree that § 8111 is "more specific," it simply does not apply to a claim that ERISA benefits were wrongly denied.

Delaware courts restrict § 8111 and its one-year statute to work or services which have already been performed and apply § 8106 to a promise of compensation for work or services to be performed. The § 8111 action, in other words, is based on the services performed rather than on the original promise while the § 8106 action is based on the underlying promise with respect to services not completed. *See Goldman v. Braunstein's, Inc.*, 240 A.2d 577, 578 (Del. 1968); *Brown v. Colonial Chevrolet Co.*, 249 A.2d 439, 441 (Del. Super. Ct. 1968).[1] Moreover, benefits for work or services which have been performed have been described in the case on which the majority primarily relies as "fringe" benefits. *Mitchell v. E.I. duPont deNemours & Co.*, 310 A.2d 641, 642 (Del. 1973). Claims for fringe benefits are typically governed by § 8111. *See e.g. , Compass v. American Mirrex Co.*, 72 F. Supp. 2d 462, 467-68 (D. Del. 1999) (claim for unpaid bonus governed by § 8111); *SCOA Industries, Inc. v. Bracken*, 374 A.2d 263, 264 (Del. 1977) (claim for year-end bonus was equivalent of "wages" and governed by § 8111).

In *Mitchell*, a pre-ERISA case, the Supreme Court of Delaware determined that Mitchell's action under Delaware's Disability Wage Plan was governed by § 8111. The Disability Wage Plan, however, had one and only one requirement for eligibility – "at least one year of continuous service." The Plan was a "fringe benefit," said the Court,

---

[1] As the majority acknowledges, selecting the appropriate statute of limitations is a matter of federal, not state, law, and thus our task is not to predict which statute of limitations the Delaware Supreme Court might select for an ERISA claim. Rather, "in borrowing the state statute of limitations to impose a time limitation on the federal cause of action, the federal court is `closing the gap' left by Congress in order to fashion a body of federal common law to supplement the federal statutory cause of action." *Harrison v. Digital Health Plan* , 183 F.3d 1235, 1238-39 (11th Cir. 1999).

which accrued to Mitchell simply because she had worked for the one year -- her "work" had been "performed." *Mitchell*, 310 A.2d at 642.

Syed's claim, however, has little or nothing to do with work or services performed or fringe benefits and has everything to do with benefits for disability based on an interpretation and analysis of the Plan documents, akin to the analysis required in a traditional breach of contract claim:

> The [claimant] has brought this action to recover benefits allegedly due him under the terms of the employee pension benefit plan and to enforce and/or clarify his rights under the terms of that Plan. The employee pension benefit plan and its predecessor . . . are in written form. Each of the Plans contain extensive and detailed terms and conditions governing the rights and duties of all participants in the fund.

Jenkins v. Local 705 Int'l Bd. of Teamsters Pension Plan, 713 F.2d 247, 252-53 (7th Cir. 1983); *see also Hogan v. Kraft Foods*, 969 F.2d 142, 145 (5th Cir. 1992) ("[The] claim involves the interpretation of the annuity contract[.]"); *Meade v. Pension Appeals and Review Comm.*, 966 F.2d 190, 195 (6th Cir. 1992) ("[T]he Plan at issue in this case constitutes a written contract [for disability benefits]."); *Johnson v. State Mut. Life Assur. Co. of America*, 942 F.2d 1260, 1264 (8th Cir. 1991) (noting that life insurance policy governed by ERISA "is a written promise to pay money if a specified condition, accidental death, occurs in the future").

Here, as in *Jenkins*, it is the Plan which will dictate the outcome of Syed's claim for unpaid disability benefits.[2]

---

[2] It also bears mention that ERISA plans involve parties outside the employment relationship such as family members, the

There is simply no reasoned basis for concluding that fringe benefits given by the employer to the employee, *i.e.* "benefits arising from . . . work, labor or personal services performed," should be stretched to include the very different pension and health benefits governed by an ERISA plan that is subject to contract interpretation. [3] The majority's two-fold rejoinder to this is not persuasive. The majority misses the point by stating the hardly startling proposition that "Syed's claim was squarely based on his prior employment," "hardly startling" because Syed, of course, had to have been an employee to have brought an ERISA claim. Beyond that, the majority's citation to one case – a preemption case which emanated from New Jersey, not Delaware – for the proposition that ERISA benefits are "often" termed fringe benefits is somewhat disingenuous. The category of funds to which the New Jersey Construction Workers' Fringe Benefit Security Act at issue in that case applied consisted "largely if not entirely of employee benefit plans governed by ERISA." *Bricklayers and*

---

insurance company, and the plan administrator, and for that reason as well a § 502(a)(1)(B) claim does not fit squarely within § 8111. *See Harrison*, 183 F.3d at 1241-42 (noting that ERISA claims may involve non-work related injuries or illnesses and, thus, concluding that state breach of contract statute was more analogous to § 502(a)(1)(B) claims than workers compensation statute).

[3] Pennsylvania has a similar statute, the Wage Payment and Collection Law, 43 P.S. § 260.1 *et seq. See Ferguson v. Greyhound Retirement and Disability Trust*, 613 F. Supp. 323, 324 (W.D. Pa. 1985) (rejecting use of wage statute – and other statutes of limitations– as most analogous and stating "[t]his is an action for recovery of benefits due under the terms of an employee pension benefit plan[.] We believe that the claim is most analogous to contract law.").

Allied Craftsmen Int'l Union Local 33 Benefit Funds v. America's Marble Source Inc., 950 F.2d 114, 118 (3d Cir. 1991).

Mitchell aside, the majority also invokes a 1956 District of Delaware case which states that § 8111 is meant to encompass all disputes arising from the employment relationship. *See Sorensen v. Overland Corp.*, 142 F. Supp. 354 (D. Del. 1956), *aff 'd*, 242 F.2d 70 (3d Cir. 1959). Separate and apart from the fact that this sweeping language emanates from a case decided long before ERISA was even a twinkle in Congress's eye, the statement which the majority quotes has been qualified in at least two post-ERISA District of Delaware cases. In *Rich v. Zeneca, Inc.*, 845 F. Supp. 162 (D. Del. 1994), relied on by Syed, the District Court found *Mitchell* and the "fairly broad" statement in *Sorenson* inapplicable to Rich's claim under ERISA that his employer wrongfully interfered with his attainment of pension and employment benefits:

> § 8111 and its one year statute of limitations for wage, salary and benefit claims should not be read as being so comprehensive as to bar all claims arising out of the employer-employee relationship. Rather [§ 8111] is directed to claims alleging a breach of a duty to pay wages, salary or overtime for work performed. Where, as here, a plaintiff alleges that a defendant has breached a different duty arising out of the employer-employee relationship, another statute of limitations may apply to the plaintiff 's claim.

Rich, 845 F. Supp. at 165. The Court concluded that Rich's claims were most analogous to the breach of contract and breach of promise claims asserted in Goldman and Brown and, thus, subject to the § 8106 three-year statute of limitations. See id. at 165-66. Parenthetically, the majority's effort to distinguish Rich by shoe-horning Syed's case into "work performed" because his benefits have been "earned"

makes no sense both on its face and because those contracted-for benefits can only be "earned" when certain criteria – criteria stated in the Plan– are met, a finding which cannot now be made.[4]

In the second post-ERISA District of Delaware case, the Court, referencing what it called the "broad interpretation" of § 8111 in *Sorensen*, found that the bonus at issue – a clear "fringe" benefit – was subject to § 8111's one-year statute of limitations. The Court summarized the distinction between § 8106 and § 8111:

> If a plaintiff alleges a breach of a duty to provide benefits or to pay wages for work already performed, then the one year statute of limitations in section 8111 governs. On the other hand, if plaintiff alleges that his employer breached a different duty arising out of the employment agreement, then the three year statute of limitations in section 8106 applies.

Compass, 72 F. Supp. 2d at 467. Just such a "different duty" has been alleged here. *See also DeWitt v. Penn-Del Directory Corp.*, 872 F. Supp. 126, 134-35 (D. Del. 1994) (§ 8106 is the

---

[4] The majority rejects a second case relied on by Syed primarily because the Court in that case did not explain why it found § 8111 inapplicable to a claim brought under a group accident insurance policy for personal injuries resulting in disability. *See Shaw v. Aetna Life Ins. Co.*, 395 A. 2d 384 (Del. Super. Ct. 1978). It is very clear, however, why the *Shaw* Court found as it did: the very specific two-year statute of limitations for personal injury claims was the perfect fit. I note, for what it is worth, that by virtue of subsequent amendments to the personal injury protection ("PIP") provisions of Delaware's No Fault Insurance Statute, actions for PIP benefits are now statutory causes of action, subject to the three-year statute of limitations of § 8106. *See Harper v. State Farm Mut. Auto. Ins. Co.*, 703 A.2d 136 (Del. 1997).

most analogous statute of limitations for ERISA § 510 claim).

Finally, the majority cites a 1995 Eighth Circuit case which applied Minnesota's two-year statute of limitations for wage claims as more analogous to a § 502(a)(1)(B) claim than the six-year statute of limitations governing contract disputes. *See Adamson v. Armco, Inc.*, 44 F.3d 650 (8th Cir.), *cert. denied*, 516 U.S. 823 (1995). Conceding that Minnesota courts have not had occasion to determine whether claims for employee benefits under an ERISA plan are wage claims, the *Adamson* Court found the issue "hardly in doubt," but cited in support of its "hardly in doubt" conclusion only pre-ERISA cases involving claims *not* for disability benefits but for unpaid vacation benefits, salary increases and "adjustment of all fringe benefits." 447 F.3d at 653. Hardly ringing support.

It is, thus, clear, at least to me, that § 8106's statute of limitations for contract actions is more analogous to an ERISA claim for the denial of benefits than that found in § 8111.[5] Moreover, in our search for the *most* analogous

---

[5] I note in passing, and only in passing because the parties have not discussed it, that § 8106 also provides a statute of limitations for "action[s] based on a statute". Delaware courts have applied the provision to § 8106/§ 8111 disputes. *See Johnson v. Williams*, 728 A.2d 1185, 1188-89 (Del. Super. Ct. 1998)(concluding that lower court's use of § 8106 where fireman sought line-of-duty disability benefits pursuant to state statute as an "action based on statute" was not clearly erroneous); *Vassallo v. Haber Elec. Co.*, 435 A.2d 1046, 1051 (Del. Super. Ct. 1981) (applying § 8106 to plaintiff 's claim that based on a state statute he should have been registered by employer to receive higher wages). Section 8106 has also been found to provide the statute of limitations for a federal RICO claim, a claim "based on a statute." *See Creamer v. General Teamsters Local Union* 326, 579 F. Supp. 1284, 1290 (D. Del. 1984). Syed's claim is indisputably based on a statute – ERISA – and

statute, we are not necessarily limited to reviewing the two presented to us. It might well be appropriate, therefore, to consider Delaware's three-year statute of limitations for claims alleging breach of insurance policies, 19 Del. C. § 3315. Other circuits have concluded that similar state statutes are the most analogous to § 502(a)(1)(B) claims and supply the appropriate statute of limitations. *See, e.g., Lang* v. *Aetna Life Ins. Co.*, 196 F.3d 1102, 1104 (10th Cir. 1999) ("Our duty . . . is to choose the most analogous state statute of limitation. While plaintiff 's ERISA claim is based upon a contract, it is more precisely based upon a contract of insurance. Therefore, we hold that the three-year statute of limitations applies to plaintiff 's claim."); *Nikaido v. Centennial Life Ins. Co.*, 42 F.3d 557, 559 (9th Cir. 1994)(using California's "limitations statute specifically for disability policies" rather than general breach of contract statute where ERISA Plan contained provision similar to that of California's insurance code); *Duchek v. Blue Cross and Blue Shield of Nebraska*, 153 F.3d 648, 649-50 (8th Cir. 1998) (applying Nebraska Insurance Statute to action for benefits under ERISA). As the *Duchek* Court put it:

> [I]t would be anomalous to characterize this suit as a contract action and then borrow Nebraska's generic contract statute of limitations rather than the specific section of the Nebraska insurance laws permitting the contractual limitation in question.

153 F.3d at 649-50.

The majority, after concluding that Syed's claim comes within § 8111's statute of limitations, recognizes that that

---

because the more specific § 8111 simply does not apply, § 8106 is arguably a more appropriate candidate for the most analogous statute of limitations for this reason as well.

does not conclusively resolve the issue because the selected statute of limitations must not be "inconsistent with national labor policy." It is, indeed, quite clear that a state's statute of limitations for ERISA claims will only be borrowed "so long as application of state statute's time period would not impede effectuation of federal policy." *Pierce County Hotel Employees and Restaurant Employees Health Trust v. Elks Lodge*, 827 F.2d 1324, 1328 (9th Cir. 1987); *see also Jenkins*, 713 F.2d at 251 ("In determining the most appropriate state statute of limitations, the court must be cognizant of and examine the underlying nature of the federal claim as well as the federal policies involved."). The majority, while finding § 8111's one-year statute of limitations to be "short," and while choosing not to discuss the policy behind ERISA, simply concludes that it "cannot say" the one-year statute of limitations is inconsistent with that policy. That conclusion is not so clear to me.

In enacting ERISA, "Congress sought to protect the interests of participants in employee benefits plans by regulating the administration of such plans and by providing participants and beneficiaries with a variety of remedies to assure compliance with the statutory framework." *Harrison*, 183 F.3d at 1239; *see also Held v. Manufacturers Hanover Leasing Corp.*, 912 F.2d 1197, 1202 (10th Cir. 1990)("The principal purpose of ERISA is to protect employees' rights to benefits under a covered plan."). While I cannot say that applying § 8111's one-year statute of limitations (which, it must be remembered, bars Syed's claim) is so unreasonable as to impede the effectuation of federal policy, I surely cannot say that we are furthering Congress's clearly stated goal by concluding that Delaware's employees have a much shorter period of time within which to file claims for the wrongful denial of

benefits than employees in virtually every other state.[6] Perhaps the Delaware Legislature will feel obliged to consider this unfortunate result. *See Johnson* , 942 F.2d at 1266 ("Either Congress, by amending ERISA, or the Missouri Legislature is free to modify the statute of limitations. Until such legislative action, we are required to hold, consistent with Missouri law, that plaintiff 's claim to enforce defendant's written promise for the payment of money is governed by the ten-year statute of limitations.").

One final note. The Supreme Court of Delaware has instructed that when a Delaware court is in doubt as to which of two statutes of limitations control, it should choose

---

[6] *See e.g., Carey v. Int'l Broth. of Elec. Workers Local 363 Pension Plan*, 201 F.3d 44, 46-47 (2d Cir. 1999)(applying New York's six-year limitations period); *Lang*, 196 F.3d at 1104 (applying Utah's three-year limitations period); *Harrison*, 183 F.3d at 1239-40 (applying Georgia's six-year limitations period); *Duchek*, 153 F.3d at 649-50 (applying Nebraska's three-year limitations period); *Blue Cross & Blue Shield of Alabama v. Sanders*, 138 F.3d 1347, 1357 (11th Cir. 1998)(applying Alabama's six-year limitations); *Daill*, 100 F.3d at 65 (applying Illinois' ten-year limitations period); *Nikaido*, 42 F.3d at 559 (applying California's three-year limitations period); *Hogan*, 969 F.2d at 145 (applying Texas' four-year limitations period); *Johnson*, 942 F.2d at 1263 (applying Missouri's ten-year limitations period); *Meade* 966 F.2d at 193, 195 (applying Ohio's fifteen-year limitations period); *Wright v. Southwestern Bell Telephone Co.*, 925 F.2d 1288, 1291 (10th Cir. 1991) (applying Oklahoma's five-year limitations period); *Pierce*, 827 F.2d at 1328 (applying Washington's six-year limitations period); *Hawaii Carpenters Trust Funds v. Waiola Carpenter Shop*, Inc., 823 F.2d 289, 297-98 (9th Cir. 1987) (applying Hawaii's six-year limitations period); *Dameron v. Sinai Hosp. of Baltimore, Inc.*, 815 F.2d 975, 981-82 (4th Cir. 1987) (applying Maryland's three-year limitations period); *Trustees for Alaska Laborers-Constr. Indus. Health and Sec. Fund v. Ferrell*, 812 F.2d 512, 517 (9th Cir. 1987) (applying Alaska's six-year limitations period).

the longer. *See Sonne v. Sacks*, 314 A.2d 194, 196 (Del. 1973). Indeed, we, ourselves, have recognized this principle in a diversity case dealing with an § 8106 and § 8111 dispute. *See Lindsey v. M.A. Zeccola & Sons, Inc.*, 26 F.3d 1236, 1245 (3d Cir. 1994). Although we, of course, are not bound to follow that sensible instruction, choosing the concededly applicable longer statute of limitations period would not only further the federal policy behind ERISA but would bring Delaware into line with all of the other states in which substantially longer statutes of limitations are applied than the one-year period deemed applicable here. I respectfully dissent.

A True Copy:
Teste:

Clerk of the United States Court of Appeals
For the Third Circuit

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 99-5472

SAJID L. SYED
Appellant

v.

HERCULES INC., a Delaware corporation; HERCULES INCORPORATED INCOME PROTECTION PLAN, an employee welfare benefit plan; HERCULES INCORPORATED, Plan Administrator of Disability Plan

---

SUR PETITION FOR REHEARING

Present: BECKER, Chief Judge, SLOVITER, MANSMANN, GREENBERG, SCIRICA, NYGAARD, ALITO, ROTH, McKEE, RENDELL, and BARRY, and FUENTES, Circuit Judges

The petition for rehearing filed by appellants in the above entitled case having been submitted to the judges who participated in the decision of this court and to all the other available circuit judges of the circuit in regular active service, and no judge who concurred in the decision having asked for rehearing, and a majority of the circuit judges of

the circuit in regular active service not having voted for rehearing by the court en banc, the petition for rehearing is denied.

By the Court,

s/ illegible
Circuit Judge

DATED: JUL 10 2000

LKJ/cc: JS
KS

APPENDIX C

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

Civil Action No. 96-62-JJF

SAJID L. SYED

Plaintiff

v.

HERCULES INCORPORATED, a Delaware Corporation; HERCULES INCORPORATED INCOME PROTECTION PLAN, an employee welfare benefit plan, and HERCULES INCORPORATED, Plan Administrator of DISABILITY PLAN,

Defendants.

John M. Stull, Esquire, Wilmington, Delaware.
Attorney for Plaintiff.

W. Harding Drane, Jr., Mary E. Copper, and Kevin R. Shannon, Esquires, of POTTER ANDERSON & CORROON LLP, Wilmington, Delaware.
Attorneys for Defendants.

MEMORANDUM OPINION

May 27, 1999
Wilmington, Delaware

s/ JOSEPH J. FARNAN JR.
FARNAN, Chief Judge

The Plaintiff, Sajid Syed, has instituted this cause of action to recover disability benefits allegedly due under Defendant Hercules Incorporated's employee benefits plan. Count I of the Complaint seeks recovery of benefits under the Employee Retirement Income Security Act of 1974 ("ERISA") §502 (a)(1)(B), 29 U.S.C. § 1132 (a)(1)(B), and Count II seeks the imposition of sanctions against the Defendants[1] for failure to comply with ERISA § 502(c), 29 U.S.C. § 1132(c). The Defendants have counterclaimed for reimbursement of certain overpayments made to the Plaintiff. Presently pending before the Court are the parties' cross-motions for summary judgment (D.I. 30, 33). For the reasons stated below, the Court will grant the defendants' Motion For Summary Judgment (D.I. 33) and deny the Plaintiff's Motion For Summary Judgment (D.I. 30).

I. Background

The Plaintiff was employed by Hercules as a chemical operator. His employment involved moving, lifting and pushing heavy objects. On or about January 31, 1992, the Plaintiff allegedly injured his back as a result of a fall while working at a Hercules facility. The Plaintiff was subsequently terminated, on March 31, 1992, as part of a reduction in force. After his termination, the Plaintiff

---

[1] The Defendants are Hercules Incorporated, a Delaware Corporation, Hercules Incorporated Income Protection Plan, and Hercules Incorporated, Administrator of Disability Plan. When referring to the Defendants collectively, the Court will hereinafter refer to the "Defendants." When referring to the Defendants individually, the Court will hereinafter refer to Hercules Incorporated as "Hercules" and will refer to Hercules Incorporated Income Protection Plan as "the Plan."

submitted a claim for long-term total disability benefits under the Plan, which was approved. The Plaintiff received long-term disability benefits from March 4, 1992 through March 31, 1994.

In February 1994, Provident Life and Accident Insurance Company ("Provident"), the Claims Fiduciary under the Plan, requested that the Plaintiff undergo an independent medical examination to determine if he was "totally disabled." Dr. Raymond M. Joson performed the independent medical examination ("IME") on March 10, 1994 and concluded that the Plaintiff probably could not do "heavy work," but was capable of "sedentary to light work." (D.I. 35 at A50). By letter dated March 31, 1994, Provident informed the Plaintiff that his disability benefits were terminated as of March 31, 1994. (Id. at A52-A53).

By letter dated April 21, 1994, the Plaintiff appealed Provident's decision to discontinue his long-term disability benefits.[2] (Id. at A54 -A55). On May 5, 1994, Provident notified the Plaintiff by letter that his appeal had been reviewed by Provident's ERISA Committee which had decide to uphold its decision to terminate the Plaintiff's long-term disability benefits. (Id. at A64-A65). The Plaintiff appealed the decision again on July 27, 1994,[3] and after

---

[2] In connection with his appeal of Provident's decision, the Plaintiff submitted the following: (1) a disability certificate from Dr. Ross M. Ufberg, dated April 18, 1994 (D.I. 35 at A63); (2) an Initial Evaluation Report from Mensana Clinic dated September 29, 1993 (Id. at A56-A59) ; (3) an EMG report from St. Francis Hospital dated June 15, 1992 (Id. at A60) ; and (4) an MRI report from Diagnostic Imaging dated June 8, 1992 (A61-A62).

[3] In connection with his second appeal, the Plaintiff submitted the following: (1) a report from Dr. Bikash Bose dated July 11, 1994 (D.I. 35 at A68) ; (2) Myelogram and Post Myelogram CT Scan reports from the Medical Center of Delaware dated June 22, 1994

review by the ERISA Committee, Provident upheld its decision to terminate benefits. (Id. at A66 - A79). On October 28, 1994, the Plaintiff requested that the ERISA Committee review his claim for disability benefits for the third time, [4] and once again, the Committee upheld its prior decision. (Id. at A80-A93). On February 24, 1995, the Plaintiff sent a written request for a copy of the plan document effective as of March 4, 1992. In response, the Defendants sent the Plaintiff a document entitled "Summary Plan Description" ("SPD") .[5] On February 6, 1996, the Plaintiff filed this cause of action under ERISA.

(Id. at A69-A70) ; (3) a disability certificate from Dr. Ufberg dated July 22, 1994 (Id. at A71); (4) a report from John Dettwyler, Ph. D. dated July 15, 1994 (Id. at A72-A75); and (5) EKG and Persantine Stress Thallium test reports from the Papastavros' Associates dated June 1, 1994 and June 2, 1994 (Id. at A76-A78).

[4] In connection with his third and final appeal, the Plaintiff submitted the following: (1) Dr. Joson's report dated March 11, 1994 (D.I. 35 at A82-A83) ; (2) Dr. Ufberg's disability certificate dated October 14, 1994 (Id. at A84) ; (3) Dr. Bose's report dated July 11, 1994 (also submitted in connection with his second appeal) (Id. at A85) ; (4) a report from Delaware Valley Rehabilitation Service, Inc. dated October 5, 1994 (Id. at A86-A89) ; and (5) a report from the Division of Vocational Rehabilitation dated September 12, 1994 (Id. at A90-A91).

[5] The Plaintiff, in his Opening Brief in Support of his Motion for Summary Judgment (D.I. 31) and in his Answer Brief in Response to Defendants' Motion for Summary Judgment (D.I. 37), represented that the Defendants produced the SPD in response to the Plaintiff's written request for a copy of the Plan document. The Plaintiff included a copy of the SPD in the Appendix to his Opening Brief in support of his Motion for Summary Judgment (D.I. 32 at A3-A20). The Plaintiff, however, subsequently filed a brief entitled "Reply Brief In Response to Defendants' Answer Brief In Support of Defendants' Motion For Summary Judgment," in which the Plaintiff claims that a different document was

II. Discussion

The Plaintiff and the Defendants have filed cross-motions for summary judgment on the following issues: (1) the Plaintiff's claim seeking recovery of benefits under ERISA § 502(a)(1)(B) , 29 U.S.C. § 1132 (a)(1)(B) ; (2) the Plaintiff's claim alleging that the Defendants failed to provide adequate written notice of the reasons for the termination of the Plaintiff's benefits as required by ERISA § 503, 29 U.S.C. § 1133 ; and (3) the Plaintiff's claim alleging that the Defendants failed to produce the Plan document in response to the Plaintiff's written request as required by ERISA § 502(c), 29 U.S.C. § 1132(c). Additionally, the Defendants move for summary judgment on their counterclaim that the Plaintiff is required to reimburse them for overpayments made under the Plan.

A. Legal Standard

Summary judgment is appropriate where admissible evidence fails to demonstrate a genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c). Rule 56 requires summary judgment where a party "fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986). In considering a motion for summary judgment, a

---

produced by the Defendants in response to the Plaintiff's request. At the time the Plaintiff submitted his so-called "Reply Brief," the only briefing submitted in connection with the Defendants' Motion for Summary Judgment was the Defendants' Opening Brief and the Plaintiff's Answer Brief. As such, the Court will strike the Plaintiff's "Reply Brief" for failure to conform to Rule 7.1.2 (a) of the Local Rules of Civil Practice and Procedures for the District of Delaware.

court does not resolve factual disputes or make credibility determinations and must view facts and inferences in the light most favorable to the non-moving party. Siegal Transfer, Inc. v. Carrier Express, Inc., 54 F.3d 1125, 1127 (3d Cir. 1995).

B. Count I

The Plaintiff has brought a claim under ERISA, § 502 (a)(1)(B), which states:

> A civil action may be brought –
>
> (1) by a participant or a beneficiary –
>
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of his plan, or to clarify his future benefits under the terms of the plan.

29 U.S.C. § 1132 (a)(1)(B). As a threshold matter, the parties disagree on the standard of review under which the Court should examine Provident's decision to terminate the Plaintiff's benefits and the definition of "total disability" under the Plan.

1. Standard of Review

The Plaintiff argues that the Defendants' decision to terminate his benefits should be examined under a de novo standard of review because the Plan document grants no discretion to the Plan Administrator in determining eligibility for benefits. Both parties agree that Hercules is the Plan Administrator and Provident is the Claims Fiduciary under the Plan. The Plaintiff contends that the Plan Administrator is responsible for reviewing and deciding entitlement claims, but the Plaintiff presents no evidence in support of such contention. The Plaintiff relies

on Ramsey v. Hercules Inc., et. al. , 77 F.3d 199, 202 (7th Cir. 1996) for the proposition that de novo review is required when the Plan dos not provide discretion to the Plan Administrator in determining eligibility for benefits under a disability benefits plan.

In response, the Defendants assert that the Plaintiff's claim was reviewed and denied by Provident, not Hercules. The Plan provides that the decision to allow or deny a claim is within the sole discretion of Provident as the Claims Fiduciary. Specifically, the Defendants note the following language found in both the SPD and the subsequently-executed Plan document : "The Claims Fiduciary has the sole and exclusive discretion and power to grant and/or deny any and all claims for benefits, and construe any and all issues relating to eligibility for benefits." (D.I. 35 at A24; A41). In Firestone Tire and Rubber Co. v. Bruch, 489 U.S. 101, 115 (1989), the U.S. Supreme Court stated:

> a denial of benefits challenged under § 1132 (a)(1)(B) [of ERISA] is to be reviewed under a de novo standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.

Id. (emphasis added). Where a plan administrator or fiduciary is granted discretionary authority to make benefit decisions under the plan, its decision to discontinue benefits "must be affirmed unless its is arbitrary and capricious." Abnathya v. Hoffman-La Roche, Inc., 2 F.3d 40,45 (3d Cir. 1993). Under the arbitrary and capricious standard, a court may overturn a decision of the claims fiduciary only if it is " 'without reason, unsupported by substantial evidence or erroneous as a matter of law.' " Id.

Based on the language found in both the SPD and the subsequently-executed Plan document, the Court concludes

that Provident, as the Claims Fiduciary, has final discretionary authority to determine eligibility for benefits. Accordingly, the Court will review Provident's decision under the arbitrary and capricious standard.

2. Definition of Total Disability

The parties are in disagreement over the definition of "total disability" under the Plan. The Defendants assert that the definition of "total disability" changes after a Plan participant has received disability benefits for 24 month. Specifically, the SPD and Plan document provide that "[d]uring . . . the first 24 months of benefit payments, you are considered totally disabled if you are not able to perform your job" (D.I. 35 at A10 (emphasis added) ; A35). After 24 months, "you are considered totally disabled for as long as you are not able to engage in any employment for wage or profit for which you are reasonably qualified by training, education, or experience" (Id.) .

In response, the Plaintiff contends that neither of the documents relied upon by the Defendants in support of their "two-tier, 24 month scheme" represent the "Plan document." As discussed further below, the Plaintiff asserts that the Plan document consists of a document entitled "Provident Life and Accident Insurance Company Application for Group Insurance" and accompanying pages entitled "Your Long Term Disability Benefit" ("Insurance Policy"), which fail to set forth a two-tier scheme. Rather, one is considered "totally disabled" under the Insurance Policy if he or she is unable to engage in "any job for gain or profit for which [he or she is] fitted by education, training, or experience." (D.I. 31 at 6-7). The Plaintiff further contends that once a person is determined to be "totally disabled" under the Plan such that they are entitled to receive long term disability benefits, those benefits can only terminate upon a change in the participant's condition. The Plaintiff

alleges that because his condition has not changed since he was deemed to be "totally disabled" and awarded long term benefits under the Plan, his termination was wrongful, and thus, he is entitled to an award of benefits under the Plan.

The Plaintiff's argument is to no avail because the definition of "total disability" set forth in the Insurance Policy and that set forth in the SPD/Plan document for participants who have received 24 months of benefits are identical. Both provide that an individual is totally disabled if he or she is not able to work at any job for gain or profit for which he or she is fitted by education, training, or experience (D.I. 35 at A116). The Plaintiff has received benefits for 24 months and would be evaluated under the "any" job standard regardless of which document controls. Thus, the Court holds that the "any" job standard, which was applied by Provident in reviewing the Plaintiff's eligibility for benefits, is the applicable standard.

3. Denial of Claim

The Plaintiff asserts that the denial of his claim was "unreasonable and not supported factually" (D.I. 31 at 12). The Defendants respond that Provident's decision to terminate the Plaintiff's benefits was reasonable in light of the Plaintiff's failure to establish that he was unable to perform "any" job and therefore "totally disabled" under the Plan. The Defendants' determination that the Plaintiff was not "totally disabled" was based on the following: (1) Dr. Joson's report, created after he examined the Plaintiff, which concludes that the Plaintiff is able to perform light to sedentary work; (2) several of the documents submitted with the Plaintiff' original claim for benefits which indicate that the Plaintiff could not perform heavy lifting but do not suggest that the Plaintiff is unable to engage in "any" employment; and (3) the Plaintiff's failure to submit any evidence in connection with his appeals of Provident's

decision that substantiate his contention that he is unable to perform "any" job.

In support of his three appeals, the Plaintiff submitted recent reports from two doctors, Dr. Ufberg and Dr. Bose, which conclude that the Plaintiff remains "totally incapacitated"[6] and "totally disabled."[7] While none of the documents specifically addresses whether the Plaintiff is "totally disabled" as defined under the Plan, this evidence is sufficient to create a genuine issue of material fact as to whether Provident acted arbitrarily and capriciously in terminating the Plaintiff's disability benefits.[8] Thus, the Court will deny both the Plaintiff's and the Defendants' motions for summary judgment on this ground.

4. Statute of Limitations

The Defendants further contend that the Plaintiff's claim under ERISA § 502 (a)(1)(B) is barred by the statute of limitations. In an action brought by a participant to recover benefits under an ERISA plan, courts look to the limitations period for the most analogous action under state law. Rich v. Zeneca, Inc., 845 F. Supp. 162, 164 (D. Del. 1994) . The Delaware Supreme Court has held that a claim by an employee for benefits under a disability wage plan is subject to the one-year statute of limitations barring claims arising out of " 'work, labor or personal services performed.' " Mitchell v. E.I. Dupont de Nemours & Co., 310 A.2d 641, 642 (Del. 1973) (citing 10 Del. C. § 8110, which is now § 8111).

---

[6] Dr. Ufberg's disability certificates dated April 18, 1994 (D.I. 35 at A63), July 22, 1994 (Id. at A71), and October 14, 1994 (Id. at A84)

[7] Dr. Bose's report dated July 11, 1994 (Id. at A68, A85).

[8] The remainder of evidence submitted by the Plaintiff in support of his appeals (see footnotes 2-4) neither advances nor weakens his claim.

The Plaintiff asserts, without support, that the three-year statute of limitations applicable to contract actions applies to the Plaintiff's claim because disability benefits are contractual in nature.

In Rich v. Zeneca, a court in this District noted that Delaware courts have consistently applied Delaware's one year statute of limitations to actions involving claims for employee benefits. Rich , 845 F. Supp. 162, 165; see Mitchell, 310 A.2d at 642. Ultimately, the court distinguished cases addressing claims for employment related benefits from the case it was considering which involved a wrongful termination claim under ERISA and thus was subject to a three-year statute of limitations. Rich, 845 F. Supp. At 166. In Mitchell, however, the Delaware Supreme Court rejected the plaintiff's attempt to characterize an ERISA claim for disability benefits as a wrongful termination claim and applied the one-year statute of limitations presently set forth at 10 Del. C. § 8111. Mitchell , 310 A.2d at 642. Section 8111 reads :

> § 8111. Work, labor or personal services.
> No action for recovery upon a claim for wages, salary, or overtime for work, labor or personal services performed, or for damages (actual, compensatory or punitive, liquidated or otherwise), or for interest or penalties resulting from the failure to pay any such claim, or for any other benefits arising from such work, labor, or personal services performed or in connection with any such action, shall be brought after the expiration of one year from the accruing of the cause of action is based.

10 Del. C. § 8111 (emphasis added). Considering a claim for disability benefits under a "Disability Wage Plan," the Delaware Supreme Court held that the Plan "conferred 'benefits arising from . . . work, labor or personal services

performed,' within the language of § 8110 [which is now § 8111]." Mitchell, 310 A. 2d at 642.

Based on the above case law, the Court concludes that the one-year statute of limitations is applicable to this action claiming disability benefits allegedly due under ERISA § 502, 29 U.S.C. § 1132. The Plaintiff filed this action on February 6, 1996 and was notified by the Defendants that his disability benefits would be discontinued on March 31, 1994. The Plaintiff has offered no argument to the contrary, and therefore, the Court concludes that the Plaintiff's claim for benefits under § 502 (a) (1) (B) is time-barred.

5. Plaintiff's Claim Under ERISA § 503

The parties have submitted cross-motions for summary judgment on the Plaintiff's claim under ERISA Section 503, which provides, in pertinent part, that every employee benefit plan shall:

> (1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and
> (2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

29 U.S.C. § 1133. The Plaintiff claims that the Defendants failed to provide detail "as to why medical information submitted is not sufficient" and failed "to provide direction as to what else is needed" (D.I. 37 at p. 14).

In response, the Defendants contend that they are entitled to summary judgment on this claim because

Provident's letter of March 31, 1994 contained the information required by § 503. Specifically, the letter set forth the following: the standard under which the Plaintiff's disability claim was evaluated; [9] the reasons why the Plaintiff's claim for additional benefits was denied; [10] alternative occupations for which the Plaintiff is qualified, taking into account the Plaintiff's work experience, education, and medical history; and the Plaintiff's appeal rights, noting that any appeal should be "accompanied by documents or records from your physician in support of your appeal." (D.I. 35, at A53).

Regulations promulgated by the Labor Department pursuant to ERISA provide that a denial notice should contain: (1) specific reasons for the denial; (2) a reference to the plan provisions on which denial was based; (3) a description of any additional material necessary to perfect a claim; and (4) a summary of the claimant's appeal rights. 29 C.F.R. § 2560.503 - 1 (f). Faced with facts similar to those presented here, the Court in Steever v. Bristol-Myers Co., 727 F. Supp. 986 (D. Md. 1989), rejected the Plaintiff's claim of insufficient notification, holding that :

---

[9] "After receiving 24 monthly payments, you are considered totally disabled for as long as you are not able to engage in any employment for wage or profit for which you are reasonably qualified by training, education, or experience" (D.I. 35, at A52).

[10] The letter stated: "[s] ince the medical documentation does not support total disability from any occupation as defined above, Long Term Disability benefits ceased effective March 31, 1994." In support of its determination that Plaintiff had not established that he was disabled from performing "any" job, Provident set forth the findings of Dr. Joson after his examination of Plaintiff, as well as Dr. Joson's conclusion that Plaintiff was "capable of doing light to sedentary work." (D.I. 35, at A52-53).

> Both the letter which initially terminated her benefits and the letter which informed her of the denial of her appeal specified that based upon the medical records she was no longer considered totally disabled. They also referred to her background, training, and education, and concluded that there are a number of occupations in which she could perform.

Id. at 991; see also Skinner v. The Administrative Committee of the W.R. Grace & Co. Long Term Disability Plan, 1992 U.S. App. LEXIS 1478, at *3 (10th Cir. Feb. 6, 1992) (holding that a letter setting forth the reason for the termination of disability benefits, the definition of "total disability" under the plan and the claimant's appeal rights and identifying a number of jobs which would be suitable for the claimant substantially complied with the requirements of § 503).

Likewise, Provident's notification to the Plaintiff contained all of the elements set forth at 19 U.S.C. § 1133 and 29 C.F.R. § 2560. 503-1(f). Because there is no genuine issue of material fact regarding the sufficiency of Provident's notification letter under § 503, the Court will grant the Defendants' Motion For Summary Judgment on the Plaintiff's § 503 claim.

C. Count II

The Plaintiff claims that the Defendants failed to comply with ERISA § 502 (c) , which states that :

> Any administrator who fails . . . to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary . . . by mailing the material requested [to the participant or beneficiary] within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of $100 a

day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

29 U.S.C. § 1132 (c) . In his Opening Brief in support of his Motion for Summary Judgment (D.I. 31), the Plaintiff asserts that, in response to the Plaintiff's written request of February 24, 1995 for a copy of the "LTD Plan document effective as of March 4, 1992" (D.I. 32 at A41), the Defendants produced a document entitled "Summary Plan Description" ("SPD") (Id. at A3-A20). The Plaintiff contends that the SPD does not represent the "plan document" as requested by the Plaintiff. Rather, the Plaintiff asserts that the Insurance Policy represents the "Plan document." (Id. at A23-A46). The Plaintiff further contends that this document was not disclosed to the Plaintiff until March 25, 1997, more than two years after his written request, thus violating ERISA § 502(c) which requires compliance with a request for information within 30 days. The Plaintiff has not submitted any evidence in support of his contention that the Insurance Policy is, in fact, the "Plan document," although he asserts that he has been prejudiced by the Defendants' failure to produce the document and urges the Court to impose sanctions upon the Defendants pursuant to its discretionary authority under § 502 (c). [11]

---

[11] The Plaintiff claims he was prejudiced because the SPD did not reveal : (1) that Provident is the Claims Fiduciary; (2) that eligibility for disability benefits is determined according to a 24-month, two-tier scheme; and (3) that partial disability benefits were available to the Plaintiff. A review of the SPD reveals that Provident is listed as the Claims Fiduciary (D.I. 32 at A18-A19) and that long-term, total disability benefits are determined according to a 24-month, two-tier scheme (Id. at A12). Additionally, the availability of the partial disability option is explained (Id. at A14-A15). Therefore, even if the Plaintiff could establish that the Insurance Policy, rather than the SPD, is the Plan

In response, the Defendants assert that : (1) at the time of the Plaintiff's request, the SPD was the acting "Plan document," (2) the currently operative Plan document was not executed until October of 1995, although it is effective as of July 1990; and (3) the document offered by the Plaintiff as the "Plan document" is not the Plan document, but rather is a contract between the Defendants and Provident, under which Provident agrees to pay benefits to the Defendants' employees according to the terms set forth in the contract. The Defendants have also moved for summary judgment on this issue (D.I. 34) and, in support, have submitted the affidavit of Douglas Hill, Director of Employee Benefits at Hercules from approximately 1995 until the present (D.I. 41 at C1-C3). Mr. Hill attests that : (1) the SPD produced to the Plaintiff was the Plan document effective on March 4, 1995; (2) the final LTD Plan document was not executed until October, 1995, but was effective as of July 1, 1990; and (3) the Insurance Policy is not the Plan document. The Defendants have submitted evidence that the document produced was the document requested by the Plaintiff, and the Plaintiff has failed to rebut such offer of proof. The Court concludes that there is no genuine issue of fact as to the Defendants' liability under § 502 (c) and thus will grant summary judgment in favor of the Defendants on Count II.

D. <u>The Defendants' Counterclaim</u>

The Defendants move for summary judgment on their counterclaim seeking reimbursement for certain overpayments that the Plaintiff received after qualifying for Social Security disability benefits. The facts presented by

---

document, the Plaintiff has failed to demonstrate that he suffered any prejudice as a result of the Defendants' alleged failure to produce the appropriate document.

the Defendants in support of their counterclaim are as follows:

The Plaintiff received disability benefits from the Plan in the amount of $1,286.67 per month for a twenty-four month period from April 1992 until March 1994. Under the terms of the Plan, such disability benefits were to be reduced by "[a]ny payments you and your family are entitled to receive from Social Security as a result of your disability" (D.I. 35, at A14, A35). At the time that the Plaintiff began receiving benefits under the Plan, his eligibility for Social Security disability benefits had not yet been determined. Accordingly, the Plaintiff had the choice of either reducing his Plan benefits by the estimated Social Security benefits, or receiving the full Plan benefits based on his promise to return any overpayments if Social Security benefits were retroactively approved (D.I. 35 at A100).

On November 13, 1992, the Plaintiff signed the Reimbursement Agreement and elected the following option:

> We can pay you a monthly benefit with no reduction for estimated Social Security benefits until Social Security makes a decision. This may result in an overpayment by us. You must supply us with a copy of the Social Security decision and agree to repay any overpayment. In addition, if Social Security makes an award, we will reduce your monthly policy benefit by the amount of Social Security benefits you and your spouse and family receive according to the policy provisions.

(D.I. 35, at A100). In the Reimbursement Agreement, the Plaintiff further agreed

> to reimburse Provident . . . , out of the initial funds received from Social Security, any overpayment

> resulting from retroactive approval by Social Security. If full reimbursement is not made I understand and agree that no further LTD payments will be paid until the overpayment is cleared.

(D.I. 35 at A100) . Thus, pending approval of his application for Social Security benefits, the Plaintiff was paid full Plan benefits without any reduction for Social Security.

In January 1995, the Plaintiff's application for Social Security disability benefits was approved, and the award of $1,043.20 per month was paid retroactively to July 1992. The Plaintiff did not notify the Plan that Social Security disability benefits had been awarded retroactively as required under the Reimbursement Agreement and did not reimburse the Plan for the overpayments relating to the period from July 1992 to March 1994, even after the Plan demanded such repayment on December 3, 1996. Further, in his Answer to the Defendants' counterclaim, the Plaintiff admitted that he is "required to reimburse the Plan for the overpayments which resulted when the Plaintiff commenced receiving benefits from Social Security," and that the overpayment consists of "the Social Security benefits received by the Plaintiff during the period that long-term disability benefits were paid by the Plan ($21,861.00) , less an allowance for attorneys' fees granted by the Social Security Administration of $5,465.25," thus totaling $16,395.75 (D.I. 19 at ¶ 52). The Defendants do not dispute this figure.

The Plaintiff has offered no evidence which tends to establish a genuine issue of material fact as to the Plaintiff's liability under the Reimbursement Agreement. Therefore, the Court will grant Defendants' Motion for Summary Judgment on their counterclaim.

An appropriate Order will be entered.

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

Civil Action No. 96-62-JJF

SAJID L. SYED

Plaintiff

v.

HERCULES INCORPORATED, a Delaware Corporation; HERCULES INCORPORATED INCOME PROTECTION PLAN, an employee welfare benefit plan, and HERCULES INCORPORATED, Plan Administrator of DISABILITY PLAN,

Defendants.

MEMORANDUM ORDER

Presently pending before the Court in this action seeking recovery of disability benefits is the Plaintiff's Motion For Reconsideration, Clarification And Reargument Of Order Entered May 28, 1999 (D.I. 48), to which the Defendants have filed a Response (D.I. 50). On May 28, 1999, the Court granted the Defendants' Motion For Summary Judgment (D.I. 33) and denied the Plaintiff's Motion For Summary Judgment (D.I. 30) by Memorandum Opinion (D.I. 46) and Order (D.I. 47). The Plaintiff now moves for reconsideration and clarification of that ruling on the grounds that : (1) a two-year statute of limitations, rather than the one-year statute of limitations applied by the Court, is applicable to the Plaintiff's ERISA claim; (2) in the alternative, the three-year limitations period contained in

the Plan document is applicable to the Plaintiff's claim; and (3) if the Court determines that the one-year limitations period applies, such limitations period should also be applied to bar the Defendants' counterclaim.

A motion for reconsideration may be filed within ten days after the filing of the Court's decision if there is : (1) an intervening change in controlling law; (2) new evidence; or (3) a need to correct a clear error of law or prevent manifest injustice. See Fed. R. Civ. P. 59(e) ; Mobil Oil Corp. v. Amoco Chems. Corp. , 915 F. Supp. 1333, 1377 (D. Del. 1994). "A Rule 59(e) motion is not to be used as a vehicle to advance additional arguments that a party could have made before judgment but neglected to do so." Id. Since the Plaintiff does not contend that there is a change in the law or new evidence, the Court will construe the Plaintiff's Motion as premised on the need to correct a clear error of law or prevent manifest injustice.

In support of his Motion, the Plaintiff first contends that the Court improperly relied upon the Delaware Supreme Court's opinion in Mitchell v. E.I. Dupont de Nemours & Co. , 310 A.2d 641 (1973) in applying the one-year statute of limitations for actions for recovery of "benefits arising from . . . work, labor or personal services performed" to the Plaintiff's claim under ERISA § 502 (a)(1)(B). See Del. C. § 8111. Rather, the Plaintiff argues that the Court should have relied upon a decision of the Superior Court of Delaware which applies the two-year statute of limitations for personal injuries to an employee's claim for personal injuries brought against the employer's group accident insurer. Shaw v. Aetna Life Insurance Co. , 395 A.2d 384 (1978).

The Plaintiff, however, did not cite Shaw, or any other case, in briefing on the summary judgment motions. Moreover, the Plaintiff argued on summary judgment that

the three-year limitations periods for actions in contract, rather than the two-year personal injury limitations period, was applicable to his ERISA claim. After reviewing the Mitchell and Shaw decisions, the Court concludes that the Mitchell decision must be followed. It is a decision of the Delaware Supreme Court and is analogous to the instant case in that the Court considered a claim for recovery of benefits under a "Disability Wage Plan," whereas Shaw involved an employee's personal injury claim against his employer's group accident insurer. Thus, the Court will deny the Plaintiff's Motion on this ground.

The Plaintiff next argues that the three-year limitations period set forth in the Plan document applies to his ERISA claim. Again, the Plaintiff did not advance this argument in briefing on summary judgment, but nevertheless, the Court concludes that the argument is without merit. In Shaw, the Superior Court held that " a contractual period of limitations which attempts to lengthen or extend the period otherwise contained in a statute violates . . . public policy" and is thus invalid. Shaw, 395 A.2d at 386. Applying this rule, the Court concludes that it must deny the Plaintiff's Motion.

Finally, the Plaintiff contends that if the Court applies the one-year statute of limitations to his ERISA claim, the Court should apply the same to the Defendants' counterclaim for reimbursement of overpayments. The Plaintiff failed to raise this statute of limitations defense in either his Answer to the Defendants' counterclaim (D.I. 19) or in briefing on summary judgment and raises it for the first time in his Motion for Reconsideration. As such, the Court concludes that the defense is waived, see Fed. R. Civ. P. 8 (c), and the Plaintiff's Motion For Reconsideration (D.I.

48) will be denied on this ground.[1] See Johnson v. Cullen, 925 F. Supp. 244, 247 n.2 (D. Del. 1996) (holding that statute of limitations is an affirmative defense that is waived if not timely pled); Feralloy Industries v. Wilson, 1998 WL 442937 at *2 (Del. Sup. June 23, 1998) (same).

NOW THEREFORE, IT IS HEREBY ORDERED this 14 day of July 1999 that the Plaintiff's Motion For Reconsideration, Clarification And Reargument Of Order Entered May 28, 1999 (D.I. 48) is DENIED.

s/ Joseph J. Farnan, Jr.
UNITE STATE DISTRICT JUDGE

---

[1] The Court notes that failure to plead an affirmative defense does not automatically constitute a waiver of the defense if the defense is raised "at a pragmatically sufficient time" and the opposing party is not prejudiced in their ability to respond. See Charpentier v. Godsil , 937 F.2d 859, 864 (3d Cir. 1991). The policy behind the statute of limitations is to put the opposing party on notice, well in advance of trial, that a party intends to pursue a defense that is in the nature of an avoidance. Blonder - Tongue Lab, Inc. v. University of Illinois Found. , 402 U.S. 313, 350 (1971). Here, however, the Court concludes that raising the defense for the first time on a motion for reconsideration of the Court's decision denying the Plaintiff's motion for summary judgment and granting summary judgment to the Defendants is not "pragmatically sufficient," does not afford the Defendants notice and an opportunity to respond meaningfully to such a defense and would indeed cause the Defendants to suffer unfair surprise and prejudice if not waived.

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

Civil Action No. 96-62-JJF

SAJID L. SYED

Plaintiff

v.

HERCULES INCORPORATED, a Delaware Corporation; HERCULES INCORPORATED INCOME PROTECTION PLAN, an employee welfare benefit plan, and HERCULES INCORPORATED, Plan Administrator of DISABILITY PLAN,

Defendants.

APPLICATION FOR SUPPLEMENTING DISCOVERY
APPLICATION FOR AMENDMENT OF COMPLAINT TO ADD PARTY

COMES NOW Plaintiff Sajid L. Syed and through counsel, makes application to this Honorable Court for leave to submit a clarifying document previously submitted in support of Plaintiff's Motion for Summary Judgment, and for leave to file an Amended Complaint to add a party whose status was undetermined as of time of original filing of Complaint in this action. In support of these two applications, Plaintiff submits the following:

CLARIFICATION OF DOCUMENT IN RECORD

1. Affidavit of Sajid L. Syed dated November 24, 1998 was included in Appendix to Plaintiff's Answer Brief in Response to Defendants' Brief in Support of Defendants' Motion for Summary Judgment which Appendix was filed November 27, 1998. This Affidavit, at B1-B4 of Appendix, was photocopied with a sticker covering pertinent information at B2 as to Plaintiff's understanding of the proper plan document reference under which he was paid his disability benefits. This information at B2, paragraphs 6 and 7, contained in an obstructed form shows that his disability benefits for his initial two-year period of disability were paid under Plan/Policy No. M-462-LTD, and not paid under Plan/Policy M-462-LTD-ASO.

2. A clean copy of this Affidavit is attached hereto to show that Plaintiff's original page/document material at page two of his Affidavit contained the necessary Plan/Policy references to indicate the correct source of funds. This supplementation is also necessary to attempt to clarify for the record Plaintiff's understanding as to the proper plan document (M-462-LTD) under which Plaintiff's disability benefit should have been defined, and pursuant to which his disability status should or should not have been determined.

3. Plaintiff's understanding and assertion as to the proper plan document is also basic to determining which plan document was in existence on July 1, 1990 in order to be in effect for determination of Plaintiff's original injury and disability status which event occurred in January-March, 1992.

4. Plaintiff's additional claim as to Defendants' not providing him with a "plan document" as a result of his

written request in February, 1995, also flows from his understanding as to the correct "plan document," which understanding is reflected in the attached unencumbered Affidavit document.

WHEREFORE, Plaintiff requests that the Court find the above reasons provide a factual and evidentiary basis for clarification of the record herein sufficient to allow the attached clarifying Affidavit to be inserted and substituted in the record.

AMENDMENT OF COMPLAINT TO ADD PARTY

1. Complaint filed February 6, 1996 was based on documents provided by Hercules Incorporated as Plan Administrator of the "Income Protection Plan" supposedly containing the disability term by which Plaintiff's disability status is fixed. Hercules Incorporated was requested by Plaintiff in writing on February 24, 1995 to provide a "complete copy of the LTD Plan document effective as of March 4, 1992." Defendants have asserted the position at pages 13-14 of their Opening Brief in Support of Summary Judgment (10/26/98) that Provident is the determiner so as to be a necessary party to this action. Plaintiff has not sought to amend his Complaint based on this assertion which Plaintiff regards as not legally correct.

2. Plaintiff's position as put forth in his Answer Brief (11/27/98), page 4-5, Statement of Facts, is that as of the point of initial claim, Hercules was the Plan Administrator, notwithstanding it eventually used Provident as a factual analyzer or other preliminary review entity. See Appendix to Reply Brief filed December 8, 1998 by Plaintiff Syed, at C16, and the reference therein to "Plan Administrator and Plan Sponsor" being "Hercules Incorporated," and being also "Named Fiduciary for This Plan" and "Agent for

Service of Process" of the Short Term/Long Term Disability "Income Protection" document.

3. The "Plan," SPD or whatever it may be termed was submitted by Affidavit of Patrick C. Donahue, Hercules Incorporated, and certified to under penalties of perjury on August 26, 1994 in the United States District Court, Southern District of Indiana, Terre Haute Division, as the Hercules Incorporated long term disability program applicable to Hercules employees. See Appendix to Plaintiff's Reply Brief, at C1-C2.

4. As a final point as to what is the "plan" or who or what entity might be the plan administrator, see again C16, Appendix to Plaintiff's Reply Brief, and the statement that "This Plan is administered through a group contract with The John Hancock Mutual Life Insurance Company (Policy Number 26701-GTC)." Because of this documentary submission by Hercules, and the conflicting assertions and documents provided at various times by Defendants, Plaintiff requests leave, if necessary to provide for a remedy should it be established by the Court, to Move for Amendment of Complaint filed in this action to add Provident.

5. As a final reason for Plaintiff not seeking to amend the Complaint herein prior to this stage of the proceedings, it has appeared clear to Plaintiff that as a legal entity status, Provident is not the "Plan Administrator" for purposes of directing a re-review of Plaintiff's disability status or awarding benefits. Hercules Incorporated has appeared to be the Plan Administrator which has final authority and which would have the final decision. Plaintiff therefore requests that the Court reserve decision as to the need to Amend the Complaint, and to allow Plaintiff the option to move to amend as may be required by this

Honorable Court's determination of Plaintiff's disability rights and benefits entitlement.

6. Any Motion to Amend Complaint to add a party (Provident) would not be prejudicial to Hercules or Provident as both parties are presently before the Court, both have had full opportunity to present a complete legal and factual position and both are represented by the same counsel.

WHEREFORE, Plaintiff requests that the Court find the above reasons provide a factual and evidentiary basis for permitting Plaintiff to be allowed to Move to Amend the Complaint herein as needed to add a party sufficient to allow an appropriate Order to issue should Plaintiff be established as having disability benefits and entitlement under the plan of Defendant Hercules.

s/ John M. Stull
John M. Stull, Esq. (Bar No. 568)
1220 North Market Street
Suite 710
P.O. Box 1947
Wilmington, DE 19899-1947
(Phone 302) 654-0399
Attorney for Plaintiff

Dated: April 1, 1999

APPENDIX F

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

Civil Action No. 96-62-JJF

SAJID L. SYED

Plaintiff

v.

HERCULES INCORPORATED, a Delaware Corporation; HERCULES INCORPORATED INCOME PROTECTION PLAN, an employee welfare benefit plan, and HERCULES INCORPORATED, Plan Administrator of DISABILITY PLAN,

Defendants.

ORDER

WHEREAS presently pending before the Court in this action is the Plaintiff's Application For Supplementing Discovery and Application For Amendment Of Complaint To Add Party (D.I. 44) ;

WHEREAS, by his motion, the Plaintiff requests leave to : (1) substitute a complete copy of a document which was previously submitted in obstructed form in Appendix to the Plaintiff's Answer Brief in Response to Defendants' Brief in Support of Defendant's Motion for Summary Judgment (D.I. 37, 38) ; and (2) amend the Complaint to add a party as may be necessary ;

WHEREAS the Court notes that the addition of a party-defendant will have no bearing on the Court's prior decision granting summary judgment to the Defendants as set forth in a Memorandum Opinion (D.I. 46) and Order (D.I. 47) dated May 28, 1999;

NOW THEREFORE, IT IS HEREBY ORDERED this 14 day of July, 1999, that:

1. The Plaintiff's Application to clarify a document in the record (D.I. 44) is **GRANTED.**

2. The Plaintiff's Application for leave to amend the Complaint to add a party (D.I. 44) is **GRANTED**, recognizing, pursuant to the Plaintiff's request, that no amendment is made to the pleadings at this time.

s/ Joseph J. Farnan, Jr.
UNITED STATES DISTRICT JUDGE

APPENDIX G

IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF DELAWARE

Civil Action No. 96-62-JJF

SAJID L. SYED

Plaintiff

v.

HERCULES INCORPORATED, a Delaware Corporation; HERCULES INCORPORATED INCOME PROTECTION PLAN, an employee welfare benefit plan, and HERCULES INCORPORATED, Plan Administrator of DISABILITY PLAN,

Defendants.

AFFIDAVIT OF J. DOUGLAS HILL

STATE OF DELAWARE)
) SS
COUNTY OF NEW CASTLE)

1. I am the Director of Employee Benefits for Hercules Incorporated ("Hercules"), and have been employed in this capacity for approximately three (3) years. I am familiar with the administrative procedures and records relating to the Hercules Long-Term Disability Plan (the "Plan").

2. On or about February 24, 1995, Hercules received a request from Sajid L. Syed for a "complete copy of LTD Plan document effective as of March 4, 1992." (Exhibit A hereto) On March 22, 1995, Hercules responded to the request (Exhibit B hereto) by providing Mr. Syed with a copy of the

Summary Plan Description for the Hercules Short Term Disability and Long-Term Disability Plans (the "SPD"). (Exhibit C hereto). At that time, the SPD was the written document pursuant to which the Plan was administered and operated. Following his receipt of the SPD, Mr. Syed did not request any additional documents.

3. On the date (March 22, 1995) that Hercules responded to Mr. Syed's request for the "LTD Plan document ," the formal Plan document had not been finalized. The final Plan document (the "Plan document") (Exhibit D hereto), however, was subsequently completed, and it is attached to the Administrative Services Agreement between Hercules and the Plan's Claims Fiduciary, Provident Life and Accident Insurance Company ("Provident") , which was executed in October 1995, but was effective as of July 1, 1990.

4. Until the Plan document was adopted, eligibility for disability benefits was determined by Provident by reference to the SPD. Thereafter, eligibility for benefits was determined by reference to the Plan Document.

5. On or about February 21, 1994, Provident issued an insurance policy (the "Insurance Policy") to Hercules relating to benefits payable under the Plan. (Exhibit E hereto). The Insurance Policy is not the Plan Document, it is a funding mechanism for the Plan. The Insurance Policy was not provided in response to Mr. Syed's February 24, 1995 letter (Exhibit A) , because it was not requested.

s/ J. Douglas Hill
J. Douglas Hill

Sworn and Subscribed before me this 4th day of December, 1998.

s/ illegible
Notary Public

My Commission Expires :

MY COMMISSION EXPIRES
FEB. 18, 2000

APPENDIX H

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
TERRE HAUTE DIVISION

LINDA RAMSEY	)	
	)	
Plaintiff,	)	
	)	Cause No:
v.	)	TH93-215-C
	)	
HERCULES INCORPORATED and	)	
PROVIDENT LIFE AND ACCIDENT	)	
INSURANCE COMPANY.	)	
	)	
Defendants.	)	
	)	

AFFIDAVIT OF PATRICK C. DONAHUE IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

Patrick C. Donahue, being first duly sworn upon his oath, deposes and says:

1. I am Director of Employee Benefits for Hercules Incorporated. I have first hand knowledge of the facts stated in this affidavit.

2. Attached as Exhibit 1 to this affidavit is a true and exact copy of the Benefits Portfolio containing the Hercules Incorporated long term disability program applicable to Hercules employees, including Linda Ramsey.

Further affiant saith not.

I affirm under the penalties of perjury that the above and foregoing representations are true.

s/ illegible
Patrick C. Donahue
Director of Employee Benefits
Hercules Incorporated

CERTIFICATE OF SERVICE

I certify that on the 26 day of August, 1994 , service of a copy of the above and foregoing pleading or document was made upon each party or attorney of record herein entitled to service thereof by depositing a copy in the United States mail , postpaid and addressed to the last known address of said party or attorney of record.

s/ illegible
David W. Sullivan

APPENDIX I

UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

No. 95-7597

DANIEL R. LOVING
Appellant

v.

PIRELLI CABLE CORPORATION, a Delaware Corporation; PENSION PLAN FOR SALARIED EMPLOYEES OF PIRELLI CABLE CORPORATION; PIRELLI CABLE CORPORATION, PLAN ADMINISTRATOR OF PENSION PLAN

Appeal from the United States District Court
For the District of Delaware
No. 94 - 205
District Judge: Honorable Roderick R. McKelvie

Argued: August 8, 1996

Before: NYGAARD, LEWIS, AND MCKEE, Circuit Judges.

JUDGMENT ORDER

After careful review of the record and consideration of all of appellant's contentions, to wit, that: (1) under the Employee Retirement Income Security Act of 1974 (ERISA) § 503, 29 U.S.C. § 1133, appellant's cause of action did not accrue until after the plan administrator had given notice denying an appeal from the decision denying benefits; (2) the three-year statute of limitations as set forth in Del. Code Ann. tit. 10 § 8106 (1975), rather than the one-year statute of limitations as set forth in Del. Code Ann. tit. 10 § 8115 (1975), applies to appellant's claim; (3) appellee's failure to provide requested plan information constituted breach of fiduciary duty; and (4) appellant's request for plan information is not subject to separate statute of limitations where request is pursuant to ERISA § 502; and (5) appellant is eligible for requested pension benefits, it is

ADJUDGED AND ORDERED that the judgment of the district court entered on October 18, 1995 be and is hereby affirmed.

Costs taxed against appellant.

BY THE COURT,

s/ illegible
Circuit Judge

Attest:

s/ P. Douglas Sisk
P. Douglas Sisk, Clerk

August 21, 1996

APPENDIX J

(Hercules logo)

Hercules Incorporated
Hercules Plaza
1313 North Market Street
Wilmington, DE 19894-0001
(302) 594-5000

March 22, 1995

Mr. Sajid L. Syed
3805 Eunice Avenue
Wilmington, DE 19808

Dear Mr. Syed:

Please see the enclosed summary plan description for the Hercules Short Term Disability and Long Term Disability Plans. per your request.

Please note that we have previously provided copies to your attorney. Keep this copy in a safe place for future reference.

Sincerely,

s/ Patrick C. Donahue
Patrick C. Donahue
Director, Benefits

PCD/efg
Encl.
March 95 PCD

APPENDIX K

PROVIDENT LIFE AND ACCIDENT INSURANCE COMPANY
LTD PAYMENT OPTIONS AND REIMBURSEMENT AGREEMENT

Claimant Sajid Syed
Social Security Number 337-64-8157
Policy M462-LTD Claim No. 92001827
Date of Disability 3-5-92

The policy under which you are covered provides that Long Term Disability benefits will be reduced by the amount of Social Security benefits which you and your spouse and family are eligible to receive.

We understand that the Social Security Administration has not yet made a decision concerning your benefits. Until the Social Security Administration makes a decision, your Long Term Disability benefit can be handled by one of the following options.

__ A. We can estimate the amount of Social Security benefits you and your spouse and family will receive and reduce your monthly policy benefit by this amount. If Social Security benefits are estimated, the monthly policy benefits will be adjusted when we receive proof of the amount awarded by Social Security benefits have been denied at the Hearing Level.

x B. We can pay you a monthly benefit with no reduction for estimated Social Security benefits until Social Security makes a decision. This may result in an overpayment by us. You must supply us with a copy of the Social Security decision and agree to repay any overpayment. In addition, if Social Security makes

an award, we will reduce your monthly policy benefit by the amount of Social Security benefits you and your spouse and family receive according to the policy provisions. If you want to elect this option but have not yet applied for Social Security benefits you must agree to apply for them immediately. If you do not apply for Social Security benefits, we will use option A.

Please tell us which approach you want to use by checking option A or option B and signing this form. If you make no selection, we will use option A.

By selecting Option B, I agree to reimburse Provident Life and Accident Insurance Company, out of the initial funds received from Social Security, any overpayment resulting from retroactive approval by Social Security. If full reimbursement is not made I understand and agree that no further LTD payments will be paid until the overpayment is cleared.

In the event benefits are denied under the Federal Social Security Act, Railroad Retirement Act or any plan or act of like intent of a foreign nation, I agree to file a request for reconsideration. If denied again, I agree to request a hearing before an Administrative Law Judge unless Provident agrees in writing to alternate terms. If you have any questions, please contact us.

I hereby acknowledge the limitations and provisions as stated in the booklet certificate of this plan.

s/ Sajid Syed Date 11/13/92
(Insured)
s/ Beverly Syed Date 11/13/92
(Spouse)
s/ Donna DeCarlo Date 11/13/92
(Witness) 455 E. New Churchman's Rd, New Castle, DE
(Witness address) 19720

FAMILY - RA2
co10

STATUTORY, REGULATORY, AND CONSTITUTIONAL PROVISIONS INVOLVED

29 U.S.C. § 1002 (1). Definitions

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

29 U.S.C. § 1002 (21)(A). Definitions

(21)(A) Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. Such term includes any person designated under section 1105(c)(1)(B) of this title.

29 U.S.C. § 1021(a). Duty of disclosure and reporting

(a) Summary plan description and information to be furnished to participants and beneficiaries.

The administrator of each employee benefit plan shall cause to be furnished in accordance with section 1024(b) of this title to each participant covered under the plan and to each beneficiary who is receiving benefits under the plan -

(1) a summary plan description described in section 1022(a)(1) of this title; and

(2) the information described in sections 1024(b)(3) and 1025(a) and (c) of this title.

29 U.S.C. § 1022. Summary plan description

(a) A summary plan description of any employee benefit plan shall be furnished to participants and beneficiaries as provided in section 1024(b) of this title. The summary plan description shall include the information described in subsection (b) of this section, shall be written in a manner calculated to be understood by the average plan participant, and shall be sufficiently accurate and comprehensive to reasonably apprise such participants and beneficiaries of their rights and obligations under the plan. A summary of any material modification in the terms of the plan and any change in the information required under subsection (b) of this section shall be written in a manner calculated to be understood by the average plan participant and shall be furnished in accordance with section 1024(b)(1) of this title.

(b) The summary plan description shall contain the following information: The name and type of administration of the plan; in the case of a group health plan (as defined in section 1191 b(a)(1) of this title), whether a health insurance

issuer (as defined in section 1191 b(b)(2) of this title) is responsible for the financing or administration (including payment of claims) of the plan and (if so) the name and address of such issuer; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are persons different from the administrator); a description of the relevant provisions of any applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan including the office at the Department of Labor through which participants and beneficiaries may seek assistance or information regarding their rights under this chapter and the Health Insurance Portability and Accountability Act of 1996 with respect to health benefits that are offered through a group health plan (as defined in section 1191 b(a)(1) of this title) and the remedies available under the plan for the redress of claims which are denied in whole or in part (including procedures required under section 1133 of this title).

29 U.S.C. § 1024(b). Filing and furnishing of information

(b) Publication of summary plan description and annual report to participants and beneficiaries of plan .

Publication of the summary plan descriptions and annual reports shall be made to participants and beneficiaries of the particular plan as follows:

(1) The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, a copy of summary plan description, and all modifications and changes referred to in section 1022(a) of this title -

(A) within 90 days after he becomes a participant, or (in the case of a beneficiary) within 90 days after he first receives benefits, or

(B) if later, within 120 days after the plan becomes subject to this part.

The administrator shall furnish to each participant, and each beneficiary receiving benefits under the plan, every fifth year after the plan becomes subject to this part an updated summary plan description described in section 1022 of this title which integrates all plan amendments made within such five-year period, except that in a case where no amendments have been made to a plan during such five-year period this sentence shall not apply. Notwithstanding the foregoing, the administrator shall furnish to each participant, and to each beneficiary receiving benefits under the plan, the summary plan description described in section 1022 of this title every tenth year after the plan becomes subject to this part. If there is a modification or change described in section 1022(a) of this title (other than a material reduction in covered services or benefits provided in the case of a group health plan (as defined in section 1191 b(a)(1) of this title)), a summary description of such modification or change shall be furnished not later than 210 days after the end of the plan year in which the change is adopted to each participant, and to each beneficiary who is receiving benefits under the plan. If there is a modification or change described in section

1022(a) of this title that is a material reduction in covered services or benefits provided under a group health plan (as defined in section 1191 b(a)(1) of this title), a summary description of such modification or change shall be furnished to participants and beneficiaries not later than 60 days after the date of the adoption of the modification or change. In the alternative, the plan sponsors may provide such description at regular intervals of not more than 90 days. The Secretary shall issue regulations within 180 days after August 21, 1996, providing alternative mechanisms to delivery by mail through which group health plans (as so defined) may notify participants and beneficiaries of material reductions in covered services or benefits.

29 U.S.C. § 1024 (b) (4)

The administrator shall, upon written request of any participant or beneficiary, furnish a copy of the latest updated summary plan description, and the latest annual report, any terminal report, the bargaining agreement, trust agreement, contract, or other instruments under which the plan is established or operated. The administrator may make a reasonable charge to cover the cost of furnishing such complete copies. The Secretary may by regulation prescribe the maximum amount which will constitute a reasonable charge under the preceding sentence.

29 U.S.C. § 1102 (a)(1). Establishment of plan

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

29 U.S.C. § 1104 (a)(1)(D). Fiduciary duties

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and -

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III of this chapter.

29 U.S.C. § 1113. Limitation of actions

No action may be commenced under this subchapter with respect to a fiduciary's breach of any responsibility, duty, or obligation under this part, or with respect to a violation of this part, after the earlier of -

(1) six years after (A) the date of the last action which constituted a part of the breach or violation, or (B) in the case of an omission the latest date on which the fiduciary could have cured the breach or violation, or

(2) three years after the earliest date on which the plaintiff had actual knowledge of the breach or violation; except that in the case of fraud or concealment, such action may be commenced not later than six years after the date of discovery of such breach or violation.

ERISA § 502 (a)(1)(B) , 29 U.S.C. § 1132 (a)(1)(B)

(a) Persons empowered to bring a civil action

A civil action may be brought -

(1) by a participant or beneficiary -

(A) for the relief provided for in subsection (c) of this

section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

ERISA § 502 (c)(1) , 29 U.S.C. § 1132 (c)(1)

(c) Administrator's refusal to supply requested information; penalty for failure to provide annual report in complete form.

(1) Any administrator (A) who fails to meet the requirements of paragraph (1) or (4) of section 1166 of this title or section 1021(e)(1) of this title with respect to a participant or beneficiary, or (B) who fails or refuses to comply with a request for any information which such administrator is required by this subchapter to furnish to a participant or beneficiary (unless such failure or refusal results from matters reasonably beyond the control of the administrator) by mailing the material requested to the last known address of the requesting participant or beneficiary within 30 days after such request may in the court's discretion be personally liable to such participant or beneficiary in the amount of up to $100 a day from the date of such failure or refusal, and the court may in its discretion order such other relief as it deems proper.

ERISA § 503 , 29 U.S.C. § 1133

In accordance with regulations of the Secretary, every employee benefit plan shall –

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under

the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

42 U.S.C. § 1983. Civil action for deprivation of rights

Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory or the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress, except that in any action brought against a judicial officer for an act or omission taken in such officer's judicial capacity, injunctive relief shall not be granted unless a declaratory decree was violated or declaratory relief was unavailable. For the purposes of this section, any Act of Congress applicable exclusively to the District of Columbia shall be considered to be a statute of the District of Columbia.

U.S. CONSTITUTION : FIFTH AMENDMENT

No person shall be held to answer for a capital, or otherwise infamous crime, unless on a presentment or indictment of a Grand Jury, except in cases arising in the land or naval forces, or in the Militia, when in actual service in time of War or public danger; nor shall any person be subject for the same offence to be twice put in jeopardy of life or limb; nor shall be compelled in any criminal case to be

a witness against himself, nor be deprived of life, liberty, or property, without due process of law; nor shall private property be taken for public use, without just compensation.

29 C.F.R. § 2520.102-3(q)

Section 102 of the Act specifies information that must be included in the summary plan description. The summary plan description must accurately reflect the contents of the plans as of the date not earlier than 120 days prior to the date such summary plan description is disclosed. The following information shall be included in the summary plan description of both employee welfare benefit plans and employee pension benefit plans, except as stated otherwise in paragraphs (j) through (n):

(q) The identity of any funding medium used for the accumulation of assets through which benefits are provided. The summary plan description shall identify any insurance company, trust fund, or any other institution, organization, or entity which maintains a fund on behalf of the plan or through which the plan is funded or benefits are provided. If a health insurance issuer, within the meaning of section 733(b)(2) of the Act, is responsible, in whole or in part, for the financing or administration of a group health plan, the summary plan description shall indicate the name and address of the issuer, whether and to what extent benefits under the plan are guaranteed under a contract or policy of insurance issued by the issuer, and the nature of any administrative services (e.g., payment of claims) provided by the issuer.

10 Del. C. § 8106. Actions subject to 3-year limitation.

No action to recover damages for trespass, no action to regain possession of personal chattels, no action to recover damages for the detention of personal chattels, no action to recover a debt not evidenced by a record or by an instrument under seal, no action based on a detailed statement of the mutual demands in the nature of debit and credit between parties arising out of contractual or fiduciary relations, no action based on a promise, no action based on a statute, and no action to recover damages caused by an injury unaccompanied with force or resulting indirectly from the act of the defendant shall be brought after the expiration of 3 years from the accruing of the cause of such action; subject, however, to the provisions of §§ 8108-8110, 8119 and 8127 of this title.

(Code 1852, § 2742; Code 1915, § 4671; Code 1935, § 5129; 46 Del. Laws, c. 115, § 1; 10 Del. C. 1953, § 8106; 57 Del. Laws, c. 568, § 2.)

10 Del. C. § 8111. Work, labor or personal services.

No action for recovery upon a claim for wages, salary, or overtime for work, labor or personal services performed, or for damages (actual, compensatory or punitive, liquidated or otherwise), or for interest or penalties resulting from the failure to pay any such claim, or for any other benefits arising from such work, labor or personal services performed or in connection with any such action, shall be brought after the expiration of one year from the accruing of the cause of action on which such action is based.

(20 Del. Laws, c. 594; Code 1915, § 4675; Code 1935, § 5133; 46 Del. Laws, c. 114; 10 Del. C. 1953, § 8110.)

10 Del. C. § 8119. Personal injuries.

No action for the recovery of damages upon a claim for alleged personal injuries shall be brought after the expiration of 2 years from the date upon which it is claimed that such alleged injuries were sustained; subject, however, to the provisions of § 8127 of this title.

(20 Del. Laws, c. 594, § 1; Code 1915, § 4675; Code 1935, § 5133; 10 Del. C. 1953, § 8118; 52 Del. Laws, c. 339, § 2; 57 Del. Laws, c. 568, § 3.)

18 Del. C. § 3914. Notice of statute of limitations required.

An insurer shall be required during the pendency of any claim received pursuant to a casualty insurance policy to give prompt and timely written notice to claimant informing claimant of the applicable state statute of limitations regarding action for his/her damages.

(63 Del. Laws, c. 236, § 1; 70 Del. Laws, c. 186, § 1.)

19 Del. C. § 2361 (b). Limitation periods for claims.

(b) Where payments of compensation have been made in any case under an agreement approved by the Board or by an award of the Board, no statute of limitation shall take effect until the expiration of 5 years from the time of the making of the last payment for which a proper receipt has been filed with the Department.